

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30470

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH ESTI- MATED	
Donald Wayne Adkins		Nov. 1, 1983	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) (LAST BIRTHDAY)
M	W	Jan 3, 1936	47 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	
Washington, DC		USA	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
Tak Park		Washington Advent Hosp	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Firefighter/Paramedic (ret)			
13a. STATE		13b. COUNTY	
Md		Montg	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
Wilbur M. Adkins, Sr		Addie Jones	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
No		578-60-9562	
17. INFORMANT		ADDRESS	
Marilyn Adkins		3001 Lee Jay Dr Capitol Hts. MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Inf.</u> 4291 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which } gave rise to immediate } cause (c) stating the under- } lying cause last. } (b) } (c) } PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			
None			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
None			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion			
ACTUAL SIGNATURE		TITLE (SPECIFY)	
John S. Rogers M.D.		MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS	
John S. Rogers		1919 seminary Rd., Sil. Spg, Md	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Burial		11-5-83	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Cedar Hill Cemetery		Suitland PG Md	
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR	
Robert E. Wilhelm Funeral Home		NOV 9 1983	
		REGISTRAR'S SIGNATURE	
		John S. Rogers	

WAS THE FOUND. GARD.

OTTO WILDER

1890

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

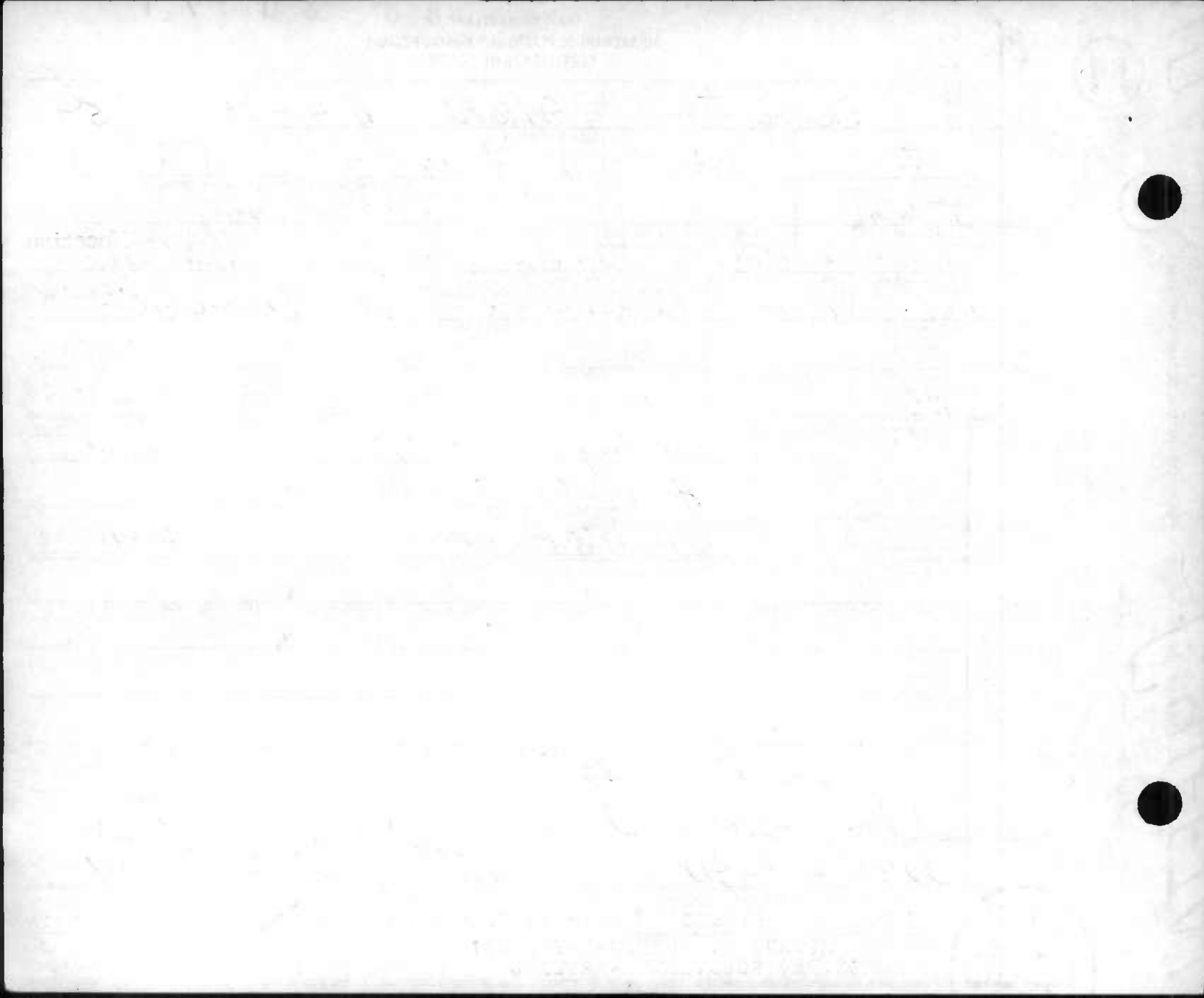
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Donna Jean Allard		2a. DATE OF DEATH MONTH DAY YEAR 11-4-83		2b. HOUR 5:00 P.M.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 12 4 34		6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Idaho		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Special Ed. Instructor		12b. KIND OF BUSINESS OR INDUSTRY Education	
13a. STATE Md.		13b. COUNTY Mont		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 1938 Dundee Rd.		14. FATHER'S NAME FIRST MIDDLE LAST James Hudson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosalie Vetch			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 519 34 8923		17. INFORMANT Husband Norman F. Allard		ADDRESS Same as item 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1919 IMMEDIATE CAUSE (a) <u>cardiopul. arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>herniation of brain stem</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Glaucoma.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes Hours Days							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11-2</u> , 19 <u>83</u> , to <u>11-4</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>11-4</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John Ford M.D.				DEGREE ATTENDING MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-5-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN L. FORD				22e. ADDRESS 344 University Blvd Silver Spring Md 20901			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Nov, 6, 1983		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia	
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, PA, ROCKVILLE, MARYLAND				25a. DATE REC'D. BY REGISTRAR NOV 7 1983		25b. REGISTRAR'S SIGNATURE John J. Conner	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ELEANOR HAMMOND ARMSTRONG</b>		2a. DATE OF DEATH MONTH <b>11</b> DAY <b>14</b> YEAR <b>83</b>		2b. HOUR <b>3:05 AM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>3</b> DAY <b>14</b> YEAR <b>1902</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.		10. CITY OR TOWN OF DEATH <b>OLNEY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BROOKE GROVE NURSING HOME</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>POST MISTRESS</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. MAIL</b>		13a. STREET ADDRESS <b>3216 Spartan Road</b>	
13b. STATE <b>MD.</b>		13c. CITY OR TOWN <b>Olney</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>LINWOOD</b> MIDDLE <b>-</b> LAST <b>HAMMOND</b>		15. MOTHER'S MAIDEN NAME FIRST <b>JESSIE</b> MIDDLE <b>-</b> LAST <b>WOOD</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	
16b. SOCIAL SECURITY NO. <b>215-44-2798</b>		17. INFORMANT <b>Dorothy Bready</b>		ADDRESS <b>Rockville, Md. 20853</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-RESP. ARREST</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASEVD.</b> (c) <b>YES.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN.</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. <b>ORGANIC BRAIN SYNDROME - SENSITIVITY.</b>					
19a. DATE OF OPERATION <b>4-18-69</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <b>4-18-69</b> to <b>11-14-83</b> that (I) (we) last saw the deceased alive on <b>11-12-83</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <b>Donald R. Lewis MD</b> DEGREE <b>MD</b>	
22c. DATES SIGNED <b>11/14/83</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DONALD R. LEWIS</b>		22e. ADDRESS <b>OLNEY, Md 20832</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>NOV. 16, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN CEMETERY</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>ROCKVILLE MONT. MD.</b>		24. FUNERAL DIRECTOR <b>FRANCIS H. BARBER</b>		25. DATE REC'D. BY REGISTRAR (BY REGISTRAR SIGNATURE) <b>NOV 17 1983</b>	

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TO		FROM		SUBJECT	
1. [illegible]		2. [illegible]		3. [illegible]	
4. [illegible]		5. [illegible]		6. [illegible]	
7. [illegible]		8. [illegible]		9. [illegible]	
10. [illegible]		11. [illegible]		12. [illegible]	
13. [illegible]		14. [illegible]		15. [illegible]	
16. [illegible]		17. [illegible]		18. [illegible]	
19. [illegible]		20. [illegible]		21. [illegible]	
22. [illegible]		23. [illegible]		24. [illegible]	
25. [illegible]		26. [illegible]		27. [illegible]	
28. [illegible]		29. [illegible]		30. [illegible]	
31. [illegible]		32. [illegible]		33. [illegible]	
34. [illegible]		35. [illegible]		36. [illegible]	
37. [illegible]		38. [illegible]		39. [illegible]	
40. [illegible]		41. [illegible]		42. [illegible]	
43. [illegible]		44. [illegible]		45. [illegible]	
46. [illegible]		47. [illegible]		48. [illegible]	
49. [illegible]		50. [illegible]		51. [illegible]	
52. [illegible]		53. [illegible]		54. [illegible]	
55. [illegible]		56. [illegible]		57. [illegible]	
58. [illegible]		59. [illegible]		60. [illegible]	
61. [illegible]		62. [illegible]		63. [illegible]	
64. [illegible]		65. [illegible]		66. [illegible]	
67. [illegible]		68. [illegible]		69. [illegible]	
70. [illegible]		71. [illegible]		72. [illegible]	
73. [illegible]		74. [illegible]		75. [illegible]	
76. [illegible]		77. [illegible]		78. [illegible]	
79. [illegible]		80. [illegible]		81. [illegible]	
82. [illegible]		83. [illegible]		84. [illegible]	
85. [illegible]		86. [illegible]		87. [illegible]	
88. [illegible]		89. [illegible]		90. [illegible]	
91. [illegible]		92. [illegible]		93. [illegible]	
94. [illegible]		95. [illegible]		96. [illegible]	
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100. [illegible]		101. [illegible]		102. [illegible]	

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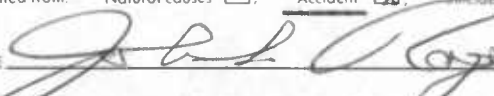
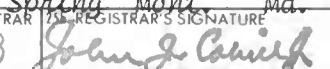
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Handwritten signature and date: 11 NOV 64

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										30473	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>John M. Arras</b>						2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11/8 19 83</b>		2b. HOUR <b>M</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jul. 10, 1935</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>48</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD <b>11/8 19 83</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b>			12b. HOUR <b>2:00 P. M.</b>		
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Health Physicist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>N. Bur. Stand.</b>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>						13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Elmer Arras</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eleanor Sullivan</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>1958-1964</b>		17. INFORMANT ADDRESS <b>Carol A. Arras Wife Same as 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>8850 IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage</u></b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) <b><u>esophageal varices</u></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b><u>cirrhosis of the liver.</u></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Fracture of left hip.</b>											
19a. DATE OF OPERATION <b>10/24/83</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Fracture of left hip.</b>						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH <b>(P.M.) 10/20 19 83</b>				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>Slipped and fell at school.</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>School</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Joseph Mill Rd., Montgomery, Silver Spring, Md.</b>			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE 						TITLE (SPECIFY) <b>Deputy</b>			MEDICAL EXAMINER <b>1919 Seminary Road</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>						ADDRESS <b>Silver Spring, Montgomery, Md.</b>			DATE SIGNED <b>11/9/83</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Nov. 12, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Mont Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 17 1983</b>			25b. REGISTRAR'S SIGNATURE 		
500 University Blvd., W. Silver Spring, Md.											

MEDICAL CERTIFICATION



BP

DHMH-16 30M 2/80  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO. 30474	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Calliope G. Athanas</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 22, 1983</b>		2b. HOUR <b>9:27 PM</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 19, 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>85</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Sparta, Greece</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA-Montgomery</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired owner Deluxe Cafe</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Md</b>		13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Chevy Chase</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>8542 Freyman Drive</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Nicholas Soffos</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Stamata Kavakos</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>254-16-9034</b>		17. INFORMANT ADDRESS <b>Chevy Chase, Md. 20815</b> <b>A Nicholas G. Athanas-son 8542 Freyman Drive</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4275 Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>generalized atherosclerosis; chronic renal failure</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/22</b> 19 <b>83</b> , to <b>11/22</b> 19 <b>83</b> , that (we) lost saw the deceased alive on <b>11/22</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Mark Rosen MD</b>		DEGREE		22c. DATE SIGNED <b>11/23/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Mark Rosen</b>		22e. ADDRESS <b>Silver Spring, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 26, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bonaventure Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Savannah Georgia</b>					
24. FUNERAL DIRECTOR NAME <b>Lee Funeral Home</b>		ADDRESS <b>300-4th St. N.E. Wash., D.C. 20002</b>		25. DATE REC'D BY REGISTRAR REGISTRAR'S SIGNATURE <b>JAN 10 1984 John J. Caneel</b>	



Nov. 22, 1953  
J. Edgar Hoover  
Director, FBI  
Washington, D.C.  
Dear Sir:  
Enclosed for you are two copies of a letterhead memorandum (LHM) dated and captioned as above.  
Very truly yours,  
J. Edgar Hoover  
Director

Nov. 26, 1953  
J. Edgar Hoover  
Director, FBI  
Washington, D.C.  
Dear Sir:  
Enclosed for you are two copies of a letterhead memorandum (LHM) dated and captioned as above.  
Very truly yours,  
J. Edgar Hoover  
Director

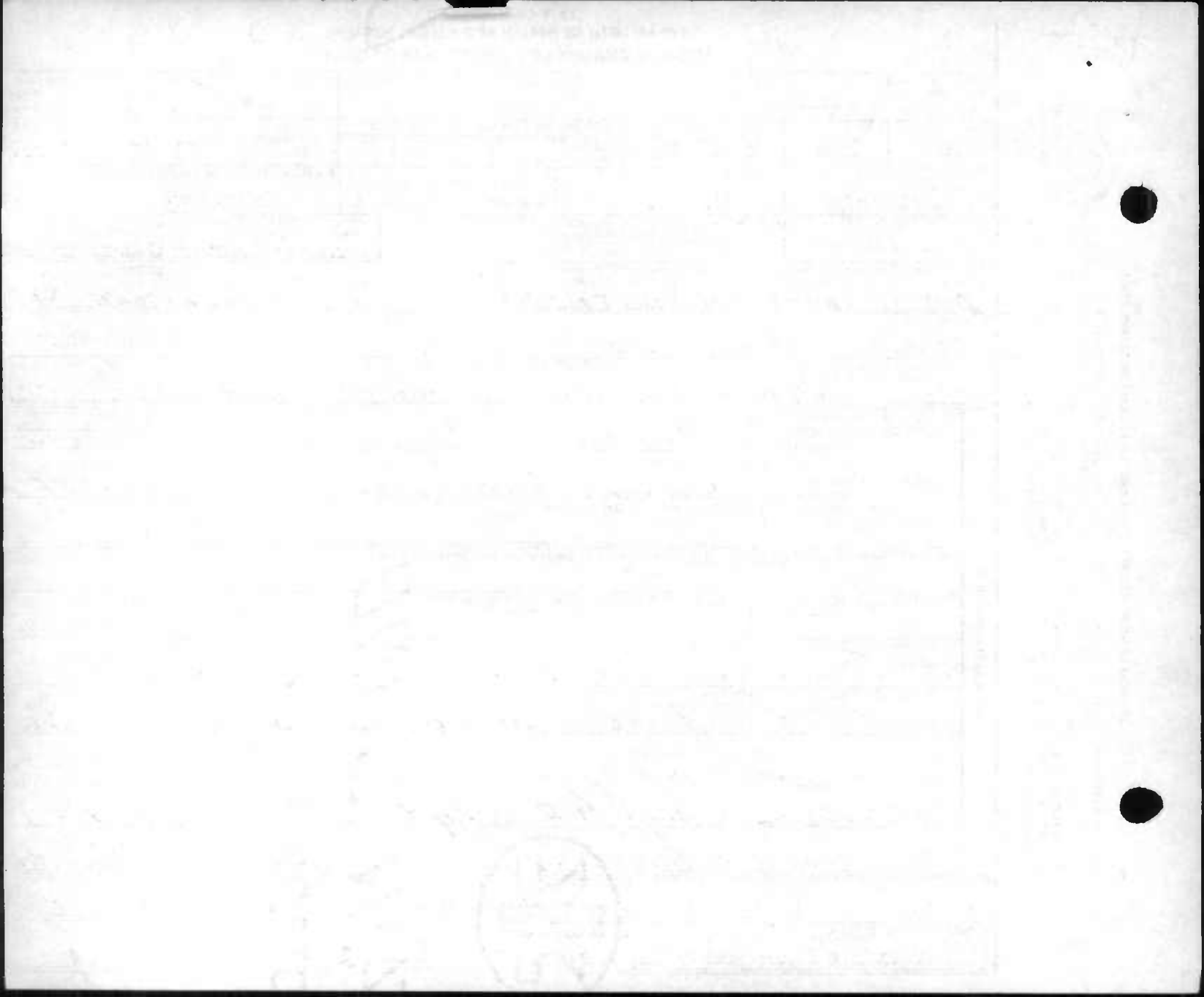


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, AND 3. RETAIN PAGE 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN DIVISION 2 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 30475	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Paul Baron</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11 20 1983</b>		2b. HOUR <b>6:55 PM</b>			
3. SEX <b>Male</b>		4. RACE <b>Cauc</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 26 30</b>		6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>53</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>11 20 1983</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Operating Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Const. Indust</b>	
13a. STATE <b>MD</b>										13b. COUNTY <b>MONTGOMERY</b>	
13c. CITY OR TOWN <b>BETHESDA</b>										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>6009 Folkstone Rd</b>										(20817)	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Klech Baron</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Lechnowsky</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>1947 to 1952 196-22-3109</b>		17. INFORMANT ADDRESS <b>Eva Baron; 6009 Folkstone Road; Bethesda, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF <b>4100</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <b>CORONARY ARTERIO SCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>ACUTE</b> <b>INDEF</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR <b>AM</b> MONTH DAY YEAR <b>11 20 1983</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>COLLAPSED AT HOME</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>		21f. LOCATION STREET <b>6009 Folkstone Rd</b> CITY OR TOWN <b>Bethesda</b> COUNTY <b>Mont</b> STATE <b>MD</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Francis C Mayle Jr</b>						TITLE (SPECIFY) <b>MD</b>		DATE SIGNED <b>11/20/83</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Francis C Mayle Jr</b>						ADDRESS <b>8200 Wisconsin Ave Bethesda MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>11/22/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Judean Memorial Gdns.</b>				23d. LOCATION CITY OR TOWN <b>Olney; Montgomery; Maryland</b> COUNTY <b></b> STATE <b></b>	
24. FUNERAL DIRECTOR <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 12 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Caniff</b>			
1170 Rockville Pike; Rockville, Maryland 20852											



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 4 7 6

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUSSELL R. BAKER			2a. DATE OF DEATH MONTH DAY YEAR 11 24 83			2b. HOUR 4:34P <sup>M</sup>	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH 12-18-02 YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, OR STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY BAKING IND.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. CITY OR TOWN Montgomery		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST BAKER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NOT AVAILABLE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 577-05-5886		17. INFORMANT ADDRESS THOMAS W. JONES, 10 OAK SHADE RD GAITHERSBURG			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Thrombosis &amp; M.I.</u> 2 hrs DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary arteriosclerosis</u> 15 yrs APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20'							18. CAUSE OF DEATH (continued)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hypertension, Chronic Bronchitis &amp; asthma, Ventric. Ectopy</u>							
19a. DATE OF OPERATION <u>3/10/83</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3/10/83</u> to <u>11/24/83</u> , that (I) (we) last saw the deceased alive on <u>10/9/83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/24/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>[Name]</u>				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE Nov. 28, 1983		23c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi Md	
24. FUNERAL DIRECTOR NAME TAKOMA Funeral Home & Crematory				25a. DATE REC'D. BY REGISTRAR NOV 28 1983		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1997-1998  
1998-1999  
1999-2000

8

2348

217-02-2806 Thomas H. Jett Jr. 10/1/1942

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30477

1. FOR  
STATE  
REGISTRAR

REG. NO.

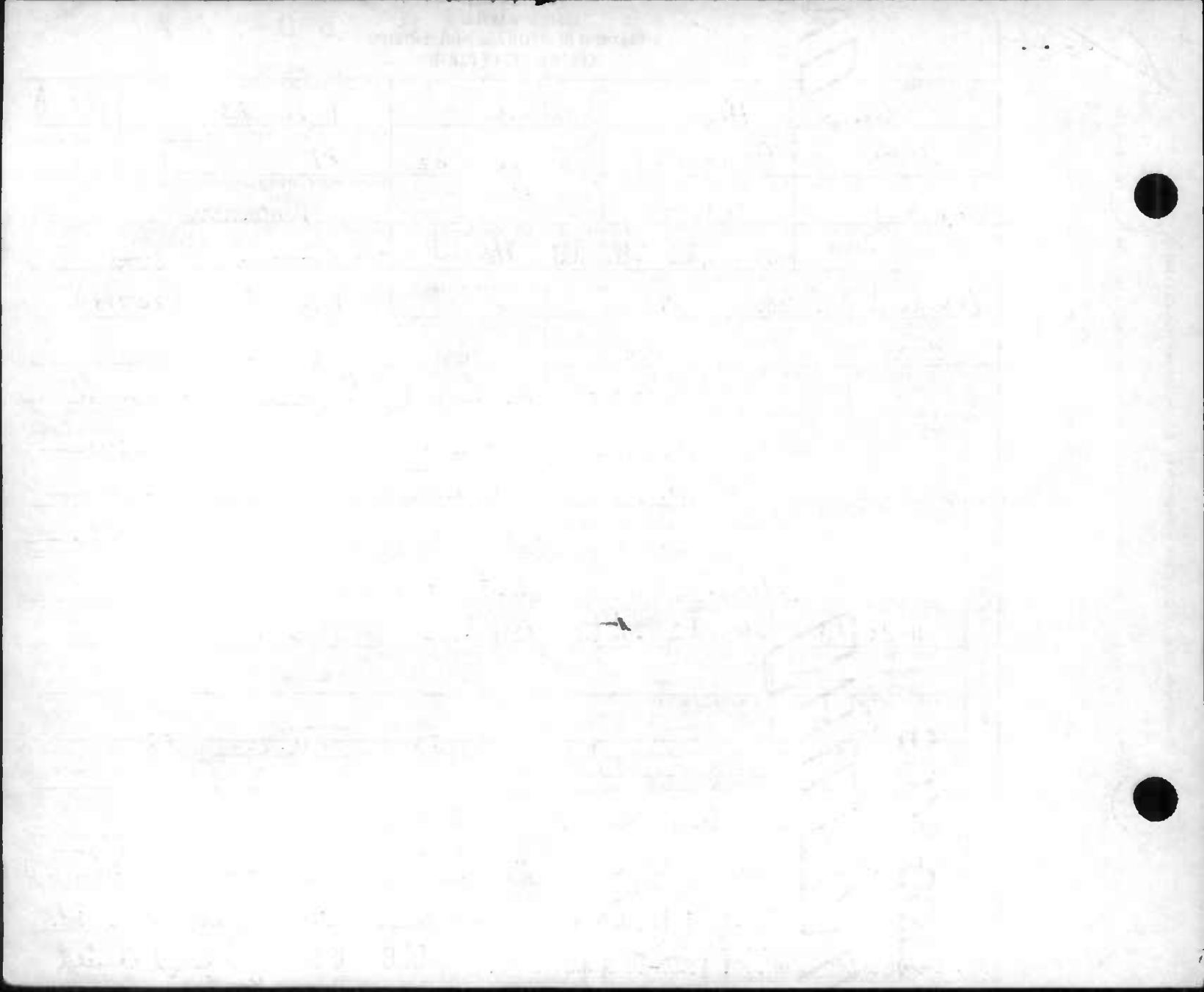
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST George Henry Bahlman			2a. DATE OF DEATH MONTH DAY YEAR 11-26-83		2b. HOUR 150 A.M.	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 11-25-02		6. AGE (IN YEARS (LAST BIRTHDAY)) 81 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.
10. CITY OR TOWN OF DEATH Tallons Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Parts Manager		12b. KIND OF BUSINESS OR INDUSTRY Sears
13a. STATE Maryland			13b. COUNTY Pr. Geo.	13c. CITY OR TOWN Arlington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Henry - Bahlman			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Snyder			16. STREET ADDRESS 8518 14th Ave. (20783)
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 578-28-3279		17. INFORMANT (NAME) ADDRESS Mrs. Anne C. Bahlman - same as above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4410 IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Atherosclerotic Heart Disease						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 224 hrs 224 hrs 224 hrs
19a. DATE OF OPERATION 11-26-83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ascending Aortic Dissection		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 11-25-83 to 11-26-83, that (I) (we) last saw the deceased alive on 11-26-1983 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Paul Darlington Kierstead, M.D.		DEGREE —		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Silver Spring, Maryland
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 30, 1983		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Mont. Md.
24. FUNERAL DIRECTOR NAME Francis J. Collins		ADDRESS 500 University Blvd., W. Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR DEC 6 1983		25b. REGISTRAR'S SIGNATURE John J. Caruth

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30478

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>REBECCA TORBERT BALLOW</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>3</b> YEAR <b>83</b>			2b. HOUR <b>10<sup>25</sup> A.M.</b>				
3. SEX <b>FEMALE</b>		4. RACE <b>CAUSC.</b>		5. DATE OF BIRTH MONTH <b>MARCH</b> DAY <b>19</b> YEAR <b>1891</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ALABAMA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.				
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>				
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONT.</b>		13c. CITY OR TOWN <b>ROCKVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>11012 ROSEMONT DR. 20852</b>		
14. FATHER'S NAME FIRST <b>JAMES</b> MIDDLE <b>A.</b> LAST <b>TORBERT</b>				15. MOTHER'S MAIDEN NAME FIRST <b>ANNA</b> MIDDLE <b></b> LAST <b>PEGUES</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>418-86-9403</b>		17. INFORMANT <b>REBECCA B. HUDSON</b>		ADDRESS <b>SAME AS 13</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> <b>4860</b> DUE TO, OR AS A CONSEQUENCE OF, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <b>10/29</b> , 19 <b>83</b> , to <b>11/2</b> , 19 <b>83</b> , that (2) (we) last saw the deceased alive on <b>11/2</b> , 19 <b>83</b> , and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (not) view the body after death.										
22b. SIGNATURE <b>Jay Weiner MD</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>11/3/83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jay Weiner MD</b>						22e. ADDRESS <b>4701 Randolph Rd Rockville, Md</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>11-5-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>EVERGREEN MEM. CEMETERY</b>		23d. LOCATION CITY OR TOWN <b>SYLACAUGA, TALLADEGA, ALA.</b> COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b> ADDRESS <b>500 UNIVERSITY BLVD. W. SILVER SPRING, MD. 20901</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





REBECCA TYPERT BALLOU

FEMALE

CAUC.

MARCH 19 1891

92

U.S.A.

KX

MONTGOMERY

SILVER SPRING

HOLY CROSS HOSPITAL

HONOLULU

HARVARD

ROCKVILLE

17016 ROSSMONT ST. 20252

JAMES

A.

TORRENT

ALMA

PEPPER

NO

418-88-9402

REBECCA E. HUSON SAIR AS 13



RELEASED BY DR. TAUBER

BP

DHMH-16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and present.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.		30479					
1. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST	
Annelise M. Barnes				2a. DATE OF DEATH		MONTH		DAY YEAR	
November 9, 1983				2b. HOUR		MIN.		5:51 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Female		Caucasian		November 14, 1940		42		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Germany		Germany				Montgomery County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Rockville		Shady Grove Adventist Hospital				Cashier		Car Wash	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	
Maryland		Montgomery		Gaithersburg				35 Long Meadow Road	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (Husband) ADDRESS	
Max Reichendact		Kolara Hudner		No		103-36-3942		35 Long Meadow Road Gaithersburg, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u>									
4373									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>increased intracranial pressure</u>									
(c) <u>survived from pulmonary embolism &amp; clot</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
11/9/83		Brain clot & Atherosclerosis		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN COUNTY STATE			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET					
22a. I certify that (I) (this hospital) attended the deceased from 11/9, 1983, to 11/9, 1983, that (I) (we) lost saw the deceased alive on 11/9, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
Bernard Stopak M.D.						Nov. 10, 1983			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
		5530 Wisconsin Avenue #820, Chevy Chase, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		Nov 12, 1983		Gate of Heaven Cemetery		Silver Spring Maryland			
24. FUNERAL DIRECTOR		24a. NAME		24b. ADDRESS		24c. DATE REC'D. BY REGISTRAR		24d. REGISTRAR'S SIGNATURE	
Robert A. Pumphrey		Funeral Homes, P.A., 300 W. Montgomery Ave., Rockville, MD				NOV 14 1983		John J. Conner	



2025 OCT 11 11:54 AM '64

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		30480				30480	
1. DECEASED NAME (TYPE OR PRINT) <b>PAUL EDWARD BARNHILL</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 19 1983</b>		2b. HOUR <b>11:26pM</b>	
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JANUARY 31 1950</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>33</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>OHIO</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>U. S. NAVY</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOSPITAL CORPS</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN <b>OHIO LOGAN BELLEFONTAINE</b>				13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS <b>320 WREN</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>PAUL EDWARD BARNHILL (SR)</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LEONIA FRANCIS CORNELL MOORE</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1977-1983 293-48-0494</b>		17. INFORMANT ADDRESS <b>444 GIRARD #104 TANYA SUE BARNHILL GAITHERSBURG MD 20877</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>1990 IMMEDIATE CAUSE (a) SQUAMOUS CELL CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>15 SEPTEMBER, 1983</b> , to <b>19 NOVEMBER, 1983</b> , that (I) (we) last saw the deceased alive on <b>19 NOVEMBER, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) sign this body after death.							
22b. SIGNATURE <i>Michael D. Canty</i>				22c. DATE SIGNED <b>20 Nov 83</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LT MICHAEL D. CANTY MC USNR</b>	
22e. ADDRESS <b>NAVAL HOSPITAL NAVAL MEDICAL COMMAND</b>				22f. ADDRESS <b>NATIONAL CAPITAL REGION BETHESDA MD 20814</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>11-21-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Andres Tucker F/H, Inc.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sandusky, Ohio</b>	
24. FUNERAL DIRECTOR <b>Marshall's Funeral Home</b> <b>4217 9th St NW: Washington, D.C.</b>				25. DATE REC'D. BY REGISTRAR <b>NOV 25 1983</b>			

DATE	DESCRIPTION	AMOUNT	REMARKS
10/1/68	...	...	...
10/2/68	...	...	...
10/3/68	...	...	...
10/4/68	...	...	...
10/5/68	...	...	...
10/6/68	...	...	...
10/7/68	...	...	...
10/8/68	...	...	...
10/9/68	...	...	...
10/10/68	...	...	...
10/11/68	...	...	...
10/12/68	...	...	...
10/13/68	...	...	...
10/14/68	...	...	...
10/15/68	...	...	...
10/16/68	...	...	...
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10/21/68	...	...	...
10/22/68	...	...	...
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10/28/68	...	...	...
10/29/68	...	...	...
10/30/68	...	...	...
10/31/68	...	...	...

Michael J. ...

Approved: [Signature] Special Agent in Charge

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30481

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Arthur R. Barwick			2a. DATE OF DEATH MONTH DAY YEAR Nov. 22 1983 2b. HOUR 10:50 A.M.		
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR March 9 1896		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COLLEGE PROFESSOR		12b. KIND OF BUSINESS OR INDUSTRY TEACHER
13a. STATE MD.			13b. COUNTY MONT.	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST ARTHUR BARWICK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DOROTHEA BOLLERMAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 578-44-L840		17. INFORMANT ADDRESS THELMA L. BARWICK, #10 WESSEX RD S.S.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

1479	IMMEDIATE CAUSE (a)	Aspiration pneumonia	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b)	Respiratory carcinoma	18 months
	(c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 18 Nov 83 to 22 Nov 83, that (I) (we) last saw the deceased alive on 21 Nov 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Michael Leibowitz, MD		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Leibowitz, MD				22e. ADDRESS 11120 New Hampshire Ave S.S. Md 20904			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov 25 1983		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Va	
24. FUNERAL DIRECTOR NAME Takoma Funeral Home, 254 Carroll St, Wash D.C.				25a. DATE REC'D. BY REGISTRAR Nov 23 1983			
				25b. REGISTRAR'S SIGNATURE J. E. Carroll			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Exp 27 151

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Ruth Elizabeth Baulsir</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 - 25 83</b>		2b. HOUR <b>7:38</b> <sup>PM</sup>
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>March 23 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Wheaton</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Manor Care Wheaton</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary-Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>NIH</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Kensington</b>	13e. STREET ADDRESS <b>11104 Newport Mill Road 20895</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John A. Miller</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary H. Snyder</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>578-01-5761</b>		17. INFORMANT <b>Husband</b> ADDRESS <b>Robert Edward Baulsir, Sr. Same as 13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>2500</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>EXTENSIVE ASCUD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>DIAPHRAGMATIC MELLIUS</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION <b>2/9</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>4/9/83</b> , 19 <b>83</b> , to <b>11/25</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>NOV 25</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Thomas E. Dooley, MD</b>		DEGREE		22c. DATE SIGNED <b>25 November 83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>THOMAS E. DOOLEY, MD</b>		22e. ADDRESS <b>17904 GEORGIA AVENUE, CLAY, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 29, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland Pr. Geo. Md.</b>		23e. DATE REC'D. BY REGISTRAR <b>DEC 2 1983</b>			
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b>		25. REGISTRAR'S SIGNATURE <b>John J. Smith</b>			
500 University Blvd., W. Silver Spring, Md.					

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 30483	
1. DECEASED NAME (TYPE OR PRINT) <b>Steven O. Beebe</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>November 5, 1983</b>	
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 20 1902</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MISSOURI</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>81</b>	
10. CITY OR TOWN OF DEATH <b>Sandy Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>17800 MARDEN LANE</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>DENTIST</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Dentistry</b>		13a. STREET ADDRESS <b>17800 MARDEN LANE</b>	
13a. STATE <b>MD.</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>SANDY SPRING</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN ADOLPHUS BEEBE</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LULU ELIZABETH PITTS</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>	
16b. SOCIAL SECURITY NO. <b>577-54-5442-A</b>		17. INFORMANT ADDRESS <b>PATRICIA BEEBE GRAHAM</b>		295 BLACKSTONE-DR. <b>SAN RAFAEL, CA.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4292 Uremia</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 mos.</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis and glomerulosclerosis</b>				<b>4 mos.</b>	
(c) <b>ASCOS &amp; Diabetes mellitus</b>				<b>15 yrs.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>CUA rt. hemiparesis and aphasia, amputation rt. leg.; sick sinus syndrome &amp; pacemaker</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 1</b> 19 <b>83</b> , to <b>Nov. 5</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>Nov. 1</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Frederick Mooman, M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>11-5-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Frederick Mooman, M.D.</b>		22e. ADDRESS <b>18111 Pt. Phyllis Dr., Olney, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Nov. 5, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematory</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C. 20002</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Lee Funeral Home 300-4th St. N.E. Wash. D.C. 20002</b>			
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>John G. Smith</b>			

BP

*[Handwritten signature]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copiers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VIRGINIA M. BEINKAMPEN			2a. DATE OF DEATH MONTH DAY YEAR 11 27 83		2b. HOUR 8:30a <sup>M</sup>
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR April 7, 1917	6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.		
10 CITY OR TOWN OF DEATH OLNEY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MONTGOMERY GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Henry Stonewall Jackson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Workman		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A	17. INFORMANT ADDRESS Nola Woodring-daughter-(same as 13e)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> 0389 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute pulmonary edema</u> (c) <u>Progressive septicemia</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Symptomatic paraplegia, chronic renal failure.</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/27</u> , 19 <u>83</u> , to <u>11</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>11/27</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Dr. R. E. Cosca</u>		DEGREE M.D.		22c. DATE SIGNED 11/27/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>RE BEB COSCA, M.D.</u>		22e. ADDRESS <u>17529 REDLAND ROAD, BETHWOOD, MD 20855</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11-30-83	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY Brentwood Pr. Georges Md.	
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home		ADDRESS 11800 N.H. Ave., Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR NOV 28 1983	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

BP

UNITED STATES  
DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

3 0 4 8 5

1. DECEASED NAME (TYPE OR PRINT) <b>Harry F Berg</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>27</b> YEAR <b>83</b>		2b. HOUR <b>12:40</b> A.M.
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH <b>JUNE</b> DAY <b>17</b> YEAR <b>1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SALESMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>JANITORIAL SUPPLIES</b>
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>P. G. CO.</b>	13c. CITY OR TOWN <b>GREENBELT</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST <b>FRANK</b> MIDDLE <b>-</b> LAST <b>BERG</b>			15. MOTHER'S MAIDEN NAME FIRST <b>PRICILLA</b> MIDDLE <b>-</b> LAST <b>ISSAC</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>109-03-5384</b>		17. INFORMANT ADDRESS <b>CHRISTINE J. BERG (WIFE) SAME AS #13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>1850 IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARCINOMATOSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) <b>CARCINOMA OF THE PROSTATE</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 YEARS</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>-</b>					
19a. DATE OF OPERATION <b>N/A</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/A</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>NOV 21</b> , 19 <b>83</b> , to <b>NOV 27</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>NOV 26</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Antonio Gargurevich, MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>NOV 27, 83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANTONIO GARGUREVICH, MD</b>		22e. ADDRESS <b>5454 WISCONSIN AVE - CHEVY CHASE, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>NOV. 28, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CREMATORY</b>	
23d. LOCATION CITY OR TOWN <b>SUITLAND AG. CO. MARYLAND</b>		23e. STATE <b>MARYLAND</b>			
24. FUNERAL DIRECTOR NAME <b>CHAMBERS FUNERAL HOME</b>		ADDRESS <b>RIVERDALE, M.D.</b>		24b. DATE RECEIVED BY REGISTRAR <b>NOV 30 1983</b>	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30486

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Leon NMN BERGEL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOV 7 1983</b>		2b. HOUR <b>10<sup>10</sup> PM</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>March 17, 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Casablanca-Morocco</b>	7b. CITIZEN OF WHAT COUNTRY? <b>Fr. Morocco</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Sil. Spring</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Levi Bergel</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Freha Ohana</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-80-9200</b>		17. INFORMANT ADDRESS <b>Silver Spring, Md. Simone Gabay; 1111 University Blvd West</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PERFORATION OF BOWEL</b> <b>5570</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>INFARCT OF BOWEL.</b> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
<b>PNEUMONIA HYPERTENSIVE AND ARTERIO-SCLEROTIC HEART DISEASE</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1977</b> to <b>NOV 7, 1983</b> , that (I) (we) last saw the deceased alive on <b>NOV 7, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Robert L. Krichmar</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>NOV 7 1983</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT L. KRICHMAR</b>		22e. ADDRESS <b>7733 ALASKA AVENUE N.W. WASHINGTON DC 20015</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-8-1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Lebanon Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hyattsville, Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Danzansky-Goldberg Chapels; 1170 Rockville Pike</b>		ADDRESS <b>Rockville, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 16 1983</b>	
				25b. REGISTRAR'S SIGNATURE <b>John J. Gansel</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1997



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpaper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				30481			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Paul Edward Bergling</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11/29/1983</b>			
3. SEX <b>Male</b>				2b. HOUR <b>10<sup>38</sup> PM</b>			
4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 27-09</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>	
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Newspaper Pressman Daily News</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Washington</b>	
13a. STATE <b>md</b>		13b. COUNTY <b>PG.</b>		13c. CITY OR TOWN <b>Takoma Park</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>909 Anne St. Takoma Park</b>		13f. ZIP CODE <b>20912</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>Gregory W. Bergling</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillian Lomelers</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>577 03 2987</b>		17. INFORMANT <b>Ann T. Bergling</b>		18. ADDRESS <b>Wife Same as 13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>2980 IMMEDIATE CAUSE (a) Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Granulocytopenia</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Cerebral atrophy Parkinson disease</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>10 Oct 1983</b> to <b>29 Nov 1983</b> , that (I) (we) last saw the deceased alive on <b>29 Oct 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Thomas P. Fogarty MD</b>				22c. DATE SIGNED <b>30 Dec 1983</b>		22d. ADDRESS <b>7676 NEW HAMPSHIRE AVE</b>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>THOMAS P FOGARTY MD</b>				22f. ADDRESS <b>7676 NEW HAMPSHIRE AVE</b>			
23a. BURIAL, CREMATION, REMOVAL SPECIFY <b>Burial</b>		23b. DATE <b>Dec. 3, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Mont. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b>				25. DATE REC'D. BY REGISTRAR <b>DEC 6 1983</b>			
500 University Blvd., W. Silver Spring, Md.				John J. Gish			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 4 8 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Lola Marcella Berry</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>November 15 1983</b>		2b. HOUR <b>11:13AM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 24, 1908</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		13a. STREET ADDRESS <b>3121 Farnborough Court 20906</b>			
13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry Garfield McCommons</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Marcella Oakley</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>--</b>		17. INFORMANT ADDRESS <b>W. H. McCommons, 506 Magnolia Road, Magnolia, Md. 21101</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4100 IMMEDIATE CAUSE (a) Cardiopolmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Anterior Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>6 days</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>29</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <b>11/10</b> 19 <b>83</b> to <b>11/15</b> 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>11/14</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If true) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Dr. Robert M.D.</b>		DEGREE		22c. DATE SIGNED <b>11/15/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert Goldberger</b>		22e. ADDRESS <b>3701 Banner Blvd - Silver Spring, Md.</b>		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 18, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cokesbury U. Methodist Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Abingdon Harford Md.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Howard K. McComas III, Abingdon, Md. 21009</b>			
25a. DATE REC'D. BY REGISTRAR <b>NOV 17 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>			

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

No.		Date		Locality		Collector		Plant		Fruit		Seed	
1		1912		Cuba		H. S. ...		...		...		...	
2		1912		Cuba		H. S. ...		...		...		...	
3		1912		Cuba		H. S. ...		...		...		...	
4		1912		Cuba		H. S. ...		...		...		...	
5		1912		Cuba		H. S. ...		...		...		...	
6		1912		Cuba		H. S. ...		...		...		...	
7		1912		Cuba		H. S. ...		...		...		...	
8		1912		Cuba		H. S. ...		...		...		...	
9		1912		Cuba		H. S. ...		...		...		...	
10		1912		Cuba		H. S. ...		...		...		...	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 30489	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>PHILLIAN GARVIS BILLINGTON</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 29 1983</b>			2b. HOUR <b>1:39<sup>a</sup> M</b>		
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MARCH 22 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MAINE</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>U.S.A.F.</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>						13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM BILLINGTON</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CARRIE UNKNOWN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1941-1963</b>		17. INFORMANT <b>ERROL BILLINGTON</b>		ADDRESS <b>2403 Sun Valley Circle</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>HEPATORENAL SYNDROME</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 12</b> , 19 <b>83</b> , to <b>NOVEMBER 29</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>NOVEMBER 29</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Peter S. Gill</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>30 NOV 83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PETER S. GILL, LT, MC, USNR</b>						22e. ADDRESS <b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>					
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>12/5/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION CITY OR TOWN <b>Ft. Myer Arlington Va.</b>					
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Funeral Home, P.A.</b> <b>Hyattsville, Maryland</b>						25a. DATE REG'D. BY REGISTRAR <b>DEC 5 1983</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Connelley</i>			

Very respectfully,  
Yours very truly,  
[Signature]

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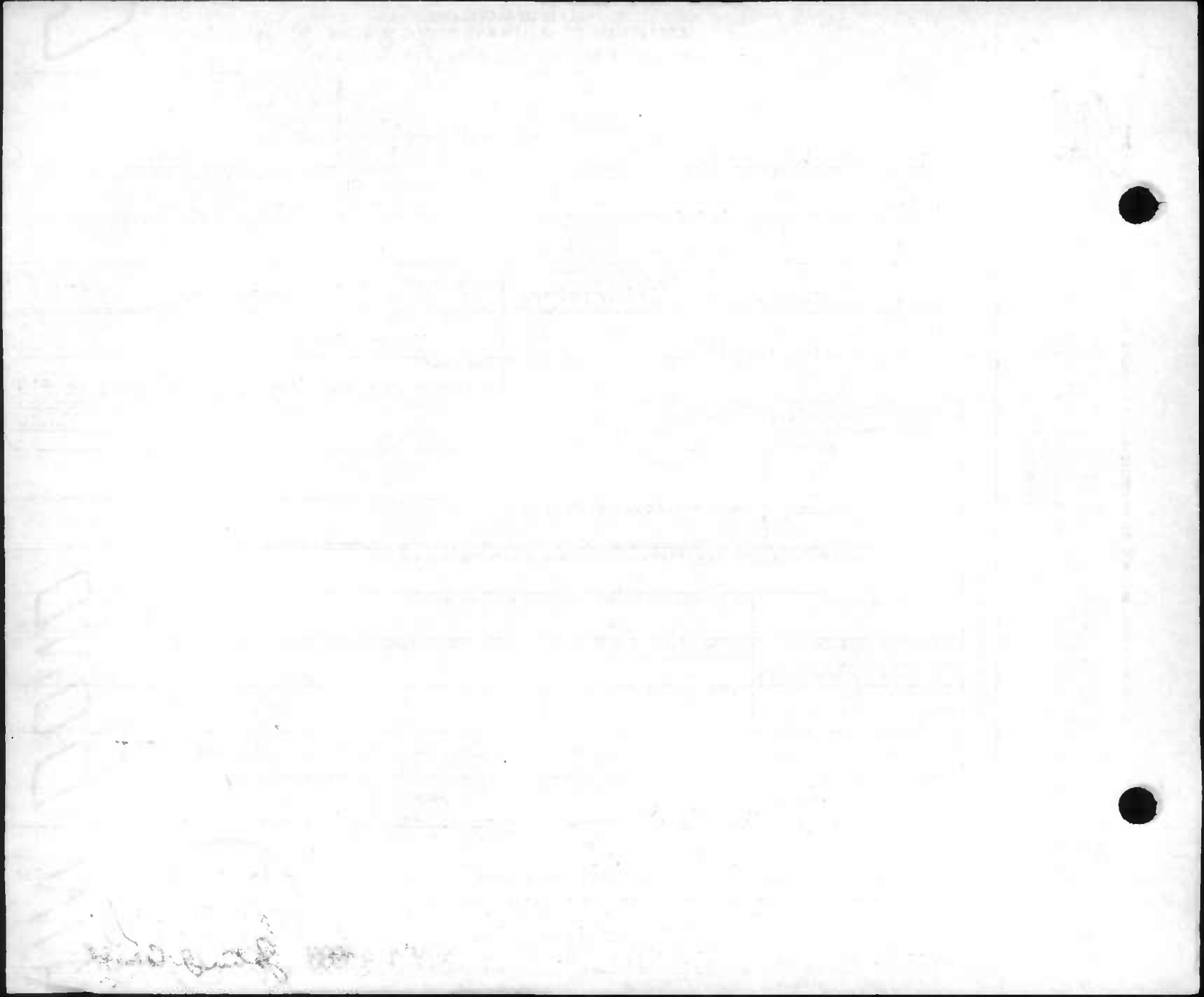
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM "PM 3. RETAIN PAGE 5 FOR VITAL RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										3 0 4 9 0 REG. NO.			
1- FOR STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST TIFFANY L. BISHOP										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 11-9-83		2b. HOUR M	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH (MONTH DAY YEAR) May 14, 1983		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. MONTHS DAYS 5 26		IF UNDER 1 YR. HOURS MIN.		2c. DATE PRONOUNCED DEAD 11-9-83		2d. HOUR 5:29A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Rockville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.				13b. COUNTY Montg.		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9402 Merust Lane		20879	
14. FATHER'S NAME FIRST MIDDLE LAST Phillip E. Smith						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tonya Bishop							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Deborah Jackson (Grandmother) same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden infant death syndrome 7980 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE 						TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER			DATE SIGNED 11-9-83	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.						ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 11-14-83		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery				23d. LOCATION CITY OR TOWN Brentwood, Pr. Geo. Md.		COUNTY STATE	
24. FUNERAL DIRECTOR NAME George R. Snowden				24b. ADDRESS 246 N. Washington St. Rockville, Md. 20850				25a. DATE REC'D. BY REGISTRAR NOV 14 1983		25b. REGISTRAR'S SIGNATURE 			

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 30491			
1. FOR STATE REGISTRAR				1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Katherine Elizabeth Bonsack			
2a. DATE OF DEATH MONTH DAY YEAR November 1, 1983				2b. HOUR 3:20 p.m.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 31, 1968		6. AGE (IN YEARS LAST BIRTHDAY) 15 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, NIH, Beth., Md		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) student		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Virginia COUNTY				13c. CITY OR TOWN Portsmouth		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Harvey Bonsack				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Porter			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO 229-11-9946		17. INFORMANT ADDRESS Harvey Bonsack (father) Same as patient			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1709 IMMEDIATE CAUSE (a) BILATERAL HEMORRHAGIC PULMONARY DUE TO, OR AS A CONSEQUENCE OF CONSOLIDATION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF EWING'S SARCOMA (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from September 25, 1983, to November 1, 1983, that (we) last saw the deceased alive on November 1, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death.							
22b. SIGNATURE John T. Sandlund, MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 11/2/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN T. SANDLUND				22e. ADDRESS Clinical Center, NIH, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-5-83		23c. NAME OF CEMETERY OR CREMATORY Olive Branch Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Portsmouth Va	
24. FUNERAL DIRECTOR Marshall's Funeral Home 4217 9th St. NW: Washington, D.C.				25a. DATE REC'D. BY REGISTRAR NOV 7 1983		25b. REGISTRAR'S SIGNATURE	



FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30492

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EUCLID WOODROW BOYER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 3, 1983</b>		2b. HOUR <b>1:10A M</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>October 28, 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>69</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Illinois</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NIH, The Clinical Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sec-Treasurer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Comm. Gas Serv</b>	
13a. STATE <b>Florida</b>		13b. COUNTY <b>—</b>		13c. CITY OR TOWN <b>Englewood</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Low Boyer</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Belle Wright</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>334-10-9201</b>	
17. INFORMANT <b>Mrs. Nancy Hunter Boyer (wife)</b>		ADDRESS <b>840 Park Road 33533</b>		18. Same <b>#13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>3949</b> IMMEDIATE CAUSE (a) <b>Hypertension - shock</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Status Post Tricuspid and Mitral Valve Replacement</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION <b>November 2, 1983</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Diseased tricuspid &amp; mitral valve</b>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>September 3, 1983</b> to <b>November 3, 1983</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>November 3, 1983</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) (did) (not) view the body after death.							
22b. SIGNATURE <i>L.R. Glassman</i>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>Nov. 3, 1983</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>L. R. Glassman M.D.</b>		22e. ADDRESS <b>National Institutes of Health, 9000 Rockville Pike, Bethesda, Maryland 20205</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov 7, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Edgar Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Paris Illinois</b>	
24. FUNERAL DIRECTOR NAME <b>IVES - PEARSONS</b>		ADDRESS <b>Arlington, VA 22201</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 7 1983</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

UNITED STATES DEPARTMENT OF THE ARMY  
HEADQUARTERS, ARMY  
WASHINGTON, D. C. 20315



CONFIDENTIAL

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		3 0 4 9 3	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH	
FIRST Maura ANN BOYES		MONTH DAY YEAR 11 30 19 83	
3. SEX F		2b. DATE PRONOUNCED DEAD	
1. RACE CAUC		MONTH DAY YEAR 11 30 19 83	
5. DATE OF BIRTH		2d. HOUR 13 30	
MONTH DAY YEAR 1 18 64		2e. HOUR 13 30	
6. AGE (IN YEARS) 19 YRS.		2f. DATE KNOWN OF DEATH	
IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		MONTH DAY YEAR 11 30 19 83	
7b. CITIZEN OF WHAT COUNTRY? United States		9. BALTIMORE CITY OR COUNTY OF DEATH	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH GREAT FALLS		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesperson	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LOWER PARKING LOT		12b. KIND OF BUSINESS OR INDUSTRY Shoes	
13a. STATE MD		13b. COUNTY MONTGOMERY	
13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 2214 McAULIFFE DR		(20851)	
14. FATHER'S NAME William W. Boyes, Jr.		15. MOTHER'S MAIDEN NAME Carol Smith	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-94-1700	
17. INFORMANT William W. Boyes, Jr. same as #13		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GUNSHOT WOUND CHEST 9554 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY 1300 P.M. 11 30 19 83	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) SHOT IN LEFT CHEST			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) PARKING LOT	
21f. LOCATION PARKING LOT		CITY OR TOWN GREAT FALLS COUNTY MONT STATE MD	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE		TITLE (SPECIFY) MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) Francis C. Moye		DATE SIGNED 11/30/83	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5, 1983	
23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION Portsmouth, Rhode Island	
24. FUNERAL DIRECTOR Robert A. Humphrey Funeral Homes, P.A. Bethesda, Maryland 20814		25a. DATE REC'D. BY REGISTRAR DEC 5 1983	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	

2



APR 11 1910

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30494

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Margaret Collins Bradley</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>November 4 1983</i>		2b. HOUR <i>9<sup>25</sup> A.M.</i>		
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Dec. 12 1909</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>73</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington, D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>William I. Collins</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Bridget Sheehan</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>216-46-4596</i>	
17. INFORMANT <i>James C. Bradley, Jr.</i>		18. ADDRESS <i>Same as 13</i>		19. HUSBAND			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> <i>4100</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>malnutrition, leg ulcers</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <i>Nov 78</i> , to <i>Nov 4</i> , 19 <i>83</i> , that (II) (we) last saw the deceased alive on <i>Nov 4</i> , 19 <i>83</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE DEGREE <i>James H. Brodsky MD</i>	
22c. DATE SIGNED <i>Nov 4, 1983</i>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>James H. Brodsky, MD</i>		22e. ADDRESS <i>4701 Willard Ave, Chevy Chase Md</i>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Nov. 7, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Silver Spring Mont. Maryland</i>	
24. FUNERAL DIRECTOR NAME <i>Francis J. Collins</i>		25a. DATE REC'D. BY REGISTRAR <i>NOV 14 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>		25c. ADDRESS <i>500 University Blvd., W. Silver Spring, Md.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

PHILEAS



*[Faint, illegible text, likely bleed-through from the reverse side of the page.]*



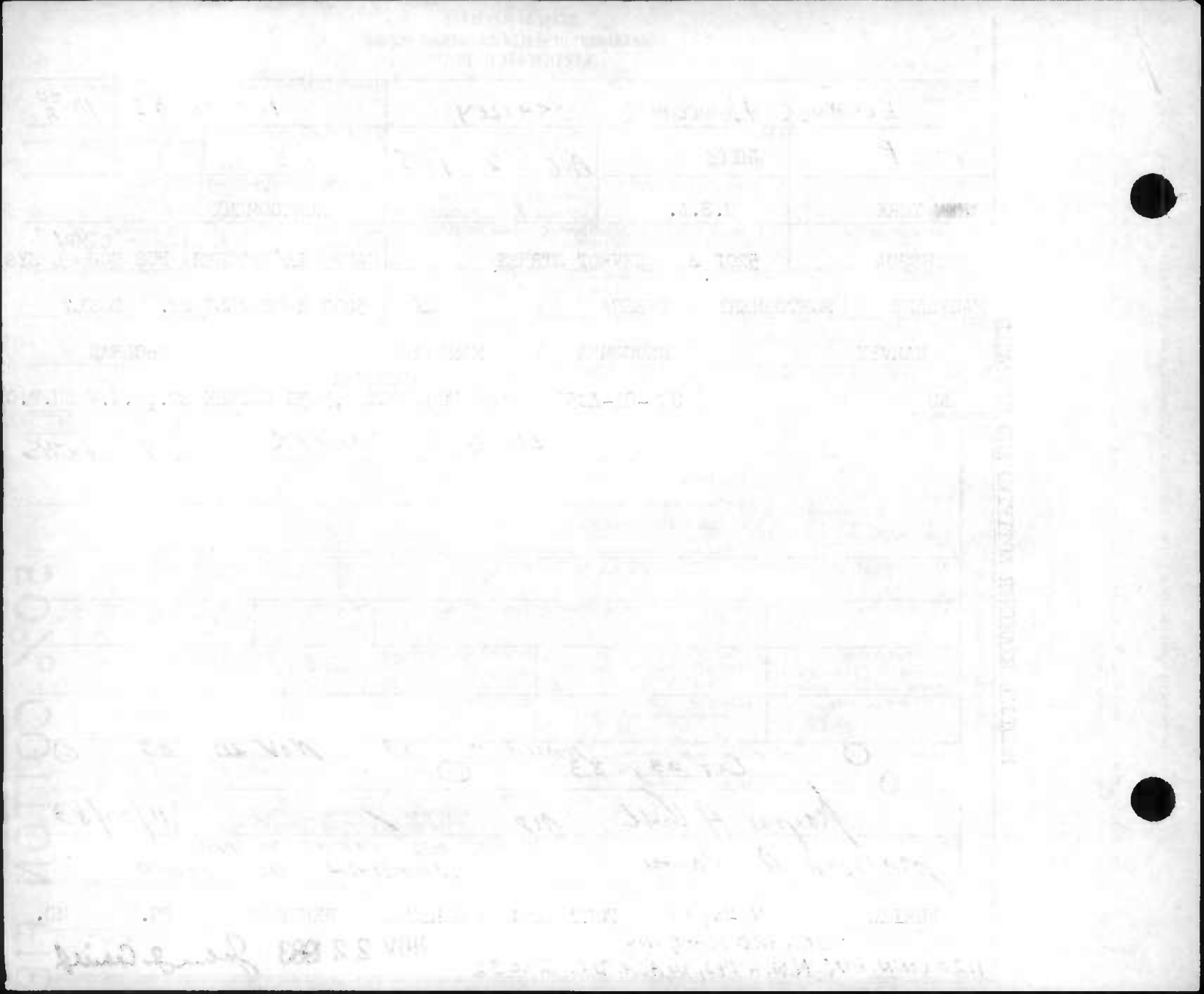
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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# MEDICAL EXAMINER NOTIFIED AND RELEASED

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				30495	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>ELEANOR NEWCOMER BRATLEY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-20-83</b>		2b. HOUR <b>10 20 AM</b>
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>AUG 2 1905</b>		6. AGE (IN YEARS, LAST BIRTHDAY) <b>78</b> YRS. MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5202 ROOSEVELT STREET</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CAMP DIR/TEACHER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CAMP/ PUB SCHOOL SYS</b>
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>	13c. CITY OR TOWN <b>BETHESDA</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>HARVEY NEWCOMER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARGARET McCLEAN</b>		13e. STREET ADDRESS <b>5202 ROOSEVELT ST. 20814</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>009-01-4050</b>		17. INFORMANT <b>DAUGHTER</b> ADDRESS <b>SUSAN HORNPOSTEL, 3030 NEWARK ST., N.W. WASH. D.C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>1629 LUNG CANCER</b> IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 MONTHS</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (1) (this hospital) attended the deceased from <b>MARCH 7 19 83</b> , to <b>Nov. 20 19 83</b> , that (1) <input checked="" type="checkbox"/> last saw the deceased alive on <b>OCT 23 19 83</b> , and that in my <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)			
22b. SIGNATURE <b>Raymond A. Voith MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/20/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARJORIE A. VOITH</b>		22e. ADDRESS <b>106 IRVING ST NW WASHINGTON, DC 20010</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11/26/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CEMETERY</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BRENTWOOD PG. MD.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>RICHARD RAPP, INC 1120 CONN. AVE. N.W. #940, WASH. D.C. 20036</b>			
25. RECEIVED BY REGISTRAR <b>NOV 22 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Casper</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

#8, File # 628 6/2/87 kam

1- STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 4 9 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ALEXANDER BREUER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 3 1983</b>		2b. HC <b>4:05</b>
3. SEX <b>MALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 6 1926</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>AUSTRIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <del>DIVORCED</del> <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD.</b>	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL, NMCNCR</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ATTORNEY/C.P.A.</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>PRIVATE LEGAL</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>PRINCE GEORGES</b>	13c. CITY OR TOWN <b>TEMPLE HILLS</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>4235 28th AVENUE, SUITE 106</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>ADOLF BREUER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ILLONA JUSTE</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1944-1946 000-06-0526</b>		17. INFORMANT ADDRESS <b>SHERRY LYNNE BREUER, BALTIMORE, MARYLAND 21209</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4310 CEREBRAL VASCULAR ACCIDENT INTRAVENTRICULAR BLEED 19 HRS</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>NOVEMBER 2</b> , 19 <b>83</b> , to <b>NOVEMBER 3</b> , 19 <b>83</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>NOVEMBER 3</b> , 19 <b>83</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) <input checked="" type="checkbox"/> saw the body after death.					
22b. SIGNATURE <b>T.G. Rainey Cdr. MC, USN</b>		DEGREE		22c. DATE SIGNED <b>11/3/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>T.G. RAINEY, CDR/MC USN, Head, CCM</b>		22e. ADDRESS <b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND NATIONAL CAPITOL REGION, BETHESDA, MD 20814</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11/4/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MOUNT LEBANON CEMETERY ADELPHI, PRINCE GEORGE'S MD.</b>	
23d. LOCATION (CITY OR TOWN) <b>ADDELPHI, PRINCE GEORGE'S MD.</b>		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR <b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.</b>					

BP

STATE OF TEXAS  
COUNTY OF DALLAS  
I, the undersigned, Clerk of the County of Dallas, State of Texas, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the County of Dallas, State of Texas.

WITNESSED my hand and the seal of the County of Dallas, State of Texas, this 1st day of May, 1901.

CLERK OF COUNTY

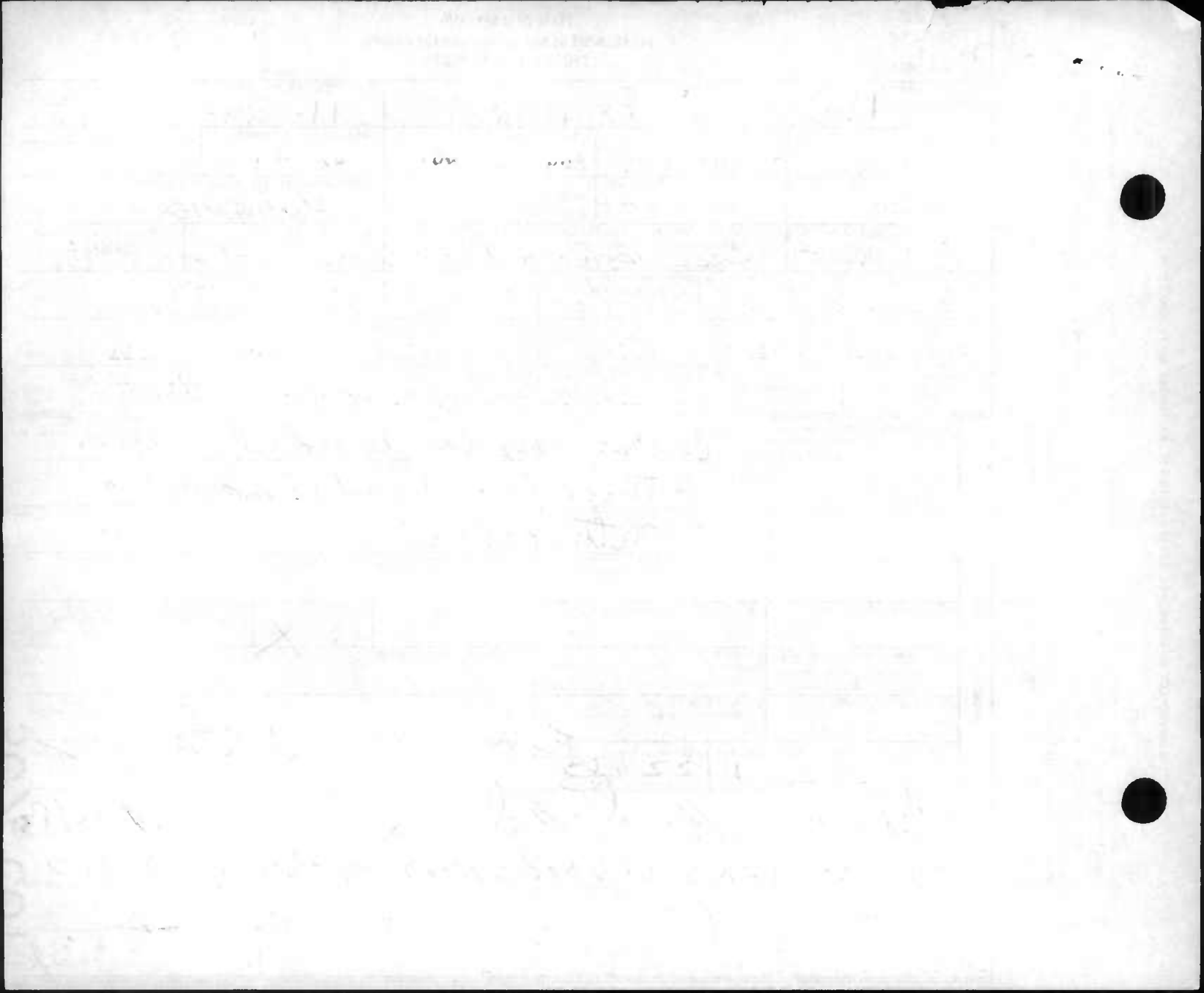
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				30497	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>First</b> <b>Middle</b> <b>Last</b> <b>Helen M. Broadhurst</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-24-83</b>		2b. HOUR <b>4:20</b> <b>P</b> <b>M</b>
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 2, 1891</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>Rockville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>COLLINGSWOOD NSG. CTR</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Dressmaker/Owner</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Doll Shop</b>
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Bethesda</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME <b>Jefferson Davis Bosley</b>			15. MOTHER'S MAIDEN NAME <b>Catherine Frances Gill</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-12-3091</b>		17. INFORMANT ADDRESS <b>P.O. Box 446</b> <b>Frances M. Trigger Gaithersburg, MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral-vascular accident</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cerebral Vases</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>gen</b> " "
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>Feb 82</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>20817</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/22/83</b> to <b>11/24/83</b> , that (I) (we) lost saw the deceased alive on <b>11/22/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Thos G. Ward</b>		22c. DEGREE <b>MD</b>		22d. DATE SIGNED <b>11/24/83</b>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thos G. WARD, 6116 Robin Road Bethesda, Md 20817</b>		22f. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov 28, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rockville Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rockville, Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey</b> ADDRESS <b>Homes, P.A. Bethesda, Maryland 20814</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 30498			
1. DECEASED NAME (TYPE OR PRINT) <b>Evelyn M. Brodie</b>										2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 23, 1983</b>		2b. HOUR a. <b>12:40</b> M	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 26, 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS MONTHS DAYS		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Massachusetts</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.							
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Fernwood Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Potomac</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>11521 Glen Road 20854</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Anthony Santes</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary E. Loveridge</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>569 30 9951</b>		17. INFORMANT ADDRESS <b>Alfred H. Brodie same as 13e</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4340 IMMEDIATE CAUSE (a) Cardiorespiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Cerebral Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cerebral Vascular Disease</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <b>12-4</b> , 19 <b>83</b> , to <b>11-23</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>10-26</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>John E. Kezcy</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-23-83</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN E. KEZCY</b>						22e. ADDRESS <b>9765 Medical Center Dr. Rockville</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/26/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring, Maryland</b>					
24. FUNERAL HOME <b>Tyson Wheeler Funeral Home, Inc.</b> <b>1331 Rockville Pike Rockville, Md. 20852</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>					

MEDICAL CERTIFICATION





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>IRIS E. BRODIE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 30, 1983</b>		2b. HOUR <b>8:30am</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 11, 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>77</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>10250 West Lake Drive</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>10250 West Lake Drive</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>JACOB ESTRIN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MIRIAM GINDIN</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>	
16b. SOCIAL SECURITY NO. <b>213-74-1758</b>		17. INFORMANT <b>Gary Brodie</b>		ADDRESS <b>13 Crestview Ct., Potomac</b>		Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**4100**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11-29</b> 19 <b>83</b> , to <b>11-30</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>11-29</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Irwin H. Ardham</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>11-30-1983</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>IRWIN H. ARDAM, M.D.</b>				22e. ADDRESS <b>5454 Wisconsin Avenue, Chevy Chase, Md.</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12-2-1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King David Mem. Gdn. Falls Church, Virginia</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Danzansky-Goldberg Chapels; 1170 Rockville Pike</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 6 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



CHIEF

BOX

STATE OF MARYLAND 83 30500  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Cassie Thompson Brown</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-5-83</b>		2b. HOUR <b>9:00AM</b>			
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 2 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS <b>84</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Gaithersburg, Montgomery Co., MD.</b>		
10. CITY OR TOWN OF DEATH <b>Gaithersburg</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>H. Wilson Health Care Center</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Glenn Mack Thompson</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Georgia Hall</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212 07 6004-D</b>		17. INFORMANT ADDRESS <b>Mr. Milton T. Brown -2540 McCulloh St.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4340</b> IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Rheumatoid arthritis</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from <b>July 21, 1983</b> , to <b>Nov 5, 1983</b> , that (1) (we) lost saw the deceased alive on <b>Oct 11, 1983</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (and not) view the body after death.								
22b. SIGNATURE <b>James R. Moore, Jr.</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11-7-83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James R. Moore, Jr.</b>		22e. ADDRESS <b>207 Brookes Ave Gaithersburg Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov 10, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>		
24. FUNERAL DIRECTOR <b>Nutter and Sons</b>		25a. DATE REC'D BY REGISTRAR <b>NOV 15 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Gault</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR	
1. DECEASED NAME FIRST MIDDLE LAST Franklin B. Brown				Nov, 7, 1983 2 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 20, 1903	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 80	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Brown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Hall		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Civil Engineer	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 279-18-6416		17. INFORMANT ADDRESS Wife - Olga E. Brown - Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 4310 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pneumonia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks years					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Pneumonia</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7-24, 1983</u> to <u>Nov. 7, 1983</u> , that (I) (we) lost saw the deceased alive on <u>Nov. 7, 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Joseph A. Romeo</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/8/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph A. Romeo		22e. ADDRESS 10401 Old Georgetown Road Bethesda, MD 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Nov. 8 '83		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Cemetery	
23d. LOCATION CITY OR TOWN Alexandria, Virginia		COUNTY Arlington		STATE Virginia	
24. FUNERAL DIRECTOR NAME <u>DeVol Funeral Home</u>		ADDRESS Washington, D.C.		15a. DATE REC'D. BY REGISTRAR NOV 14 1983	
15b. REGISTRAR'S SIGNATURE <u>James E. Grier</u>					

BP



Nov 13 1904

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 30502

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Robert C Brown</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>20</b> YEAR <b>83</b>			2b. HOUR <b>9:50</b> AM <b>A</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH <b>Oct.</b> DAY <b>25</b> YEAR <b>1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Oregon</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD	
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Lt. Col. US Airforce</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Military U.S. Govt.</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>	
14. FATHER'S NAME FIRST <b>Thorwald</b> MIDDLE <b>Brown</b> LAST <b>Brown</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Bertha</b> MIDDLE <b>Curtis</b> LAST <b>Curtis</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1942-1964</b>		17. INFORMANT <b>Wife</b> <b>Thelma R. Brown</b>		ADDRESS <b>Same as item 13</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CARDIO PULMONARY ARREST**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **METASTATIC BRAIN TUMOR**

DUE TO, OR AS A CONSEQUENCE OF

(c) **BRONCHOGENIC CARCINOMA**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

**Hours**

**2 years**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **a**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>June 4</b> , 19 <b>81</b> , to <b>Nov. 20</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>November 14</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (do) (did not) view the body after death.							
22b. SIGNATURE <b>Eric Six</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/20/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ERIC SIX</b>		22e. ADDRESS <b>Dept NeuroSurgery, NMMC, Bethesda Md</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 23, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION CITY OR TOWN <b>Arlington</b> COUNTY <b>Virginia</b> STATE	
24. FUNERAL DIRECTOR NAME <b>ROBERT A. PUMPHREY</b> ADDRESS <b>ROCKVILLE, MARYLAND</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 23 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use on the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Cleared by Dr. Mayle

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 30503				
1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM R. BRYAN</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>11-29-83</b>			2b. HOUR <b>1710 M</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MARCH 21, 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b>		7. UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>			
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SHADY GROVE ADVENTIST Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>construction</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Brookeville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>28 High St. 20833</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William H. Bryan</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Belle R. Parsley</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>219-05-6894</b>		17. INFORMANT ADDRESS <b>Grace E. Bryan Same as #13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction - Cardiogenic Shock</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>3 yrs</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>3/15</b> , 19 <b>82</b> , to <b>10/6</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>10/6</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Daniel Goldberg</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11/29/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Daniel Goldberg</b>				22e. ADDRESS <b>10401 Old Georgetown Rd - Bethesda, Md</b>					
23a. BURIAL, CREMATION, REMOVAL SPEC <b>Burial</b>		23b. DATE <b>Dec. 2, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Salem Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brookeville Mont. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Francis H. Barber Laytonsville, Md. 20879</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 5 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conish</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Infant Girl</i> <i>Burke</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>11</i> <i>9</i> <i>83</i>		2b. HOUR <i>3:00 PM</i>	
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>11</i> <i>9</i> <i>83</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>1</i> <i>50</i>		
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>N/A</i>		
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Poolesville</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Lawrence W Burke</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Linda Grosch</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT ADDRESS <i>Lawrence W. Burke Father Same as 13</i>		
17. INFORMANT ADDRESS <i>Lawrence W. Burke Father Same as 13</i>		17. INFORMANT ADDRESS <i>Lawrence W. Burke Father Same as 13</i>		17. INFORMANT ADDRESS <i>Lawrence W. Burke Father Same as 13</i>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <i>7650 IMMEDIATE CAUSE (a) Asphyxia</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) <i>Cardio-respiratory failure</i>	
		(c) <i>Extreme prematurity</i>	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Georgis G Kefale</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11/9/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Georgis G Kefale</i>		22e. ADDRESS <i>12902 Dean Rd SS MD 20906</i>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>Nov. 11, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Metropolitan Crematory</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Alexandria Virginia</i>	
24. FUNERAL DIRECTOR NAME <i>Francis J. Collins</i>		ADDRESS <i>500 University Boulevard, West Silver Spring, Md.</i>		25. DATE REC'D. BY REGISTRAR <i>NOV 17 1983</i>		25. REGISTRAR'S SIGNATURE <i>John J. Connel</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 22 is marked, the medical examiner must sign the certificate.

TO DR. J. BLAINE FITZGERALD, M.D. BY DR. WHELTON, M.E.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 30505				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Catherine M. BURNS</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>11 06 83</b>				
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>January 4 1922</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>61</b> YRS.		7b. HOUR MIN. <b>7 15 P M</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD.</b>			
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUBURBAN HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Stat. Anal.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>N.I.H.</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Kensington</b>		13e. STREET ADDRESS / ZIP CODE <b>10909 Stillwater Avenue 20895</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Michael J. Moran</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret M. Droney</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>597-28-8007</b>		17. INFORMANT ADDRESS <b>Daughter Patricia B. Miller 11005 Cripplegate Rd. Potomac, Md. 20854</b>					
18. CAUSE OF DEATH (Enter only one cause per item 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4140 Cardio Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immed.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <b>Bilateral Carotid Artery Stenosis</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>2/14 19 62</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>2/14 62 11/6 83</b>		22a. I certify that (1) the hospital attended the deceased from <b>5/13 83</b> to <b>11/6 83</b> , that (we) last saw the deceased alive on <b>5/13 83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated			
22b. SIGNATURE <b>J. Blaine Fitzgerald, M.D.</b>		22c. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. Blaine Fitzgerald, M.D.</b>		22d. ADDRESS <b>8218 Wisconsin Ave Bethesda</b>		22e. DATE SIGNED <b>11/7/83</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 9, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Mont. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b>				24. ADDRESS <b>500 University Blvd., W. Silver Spring, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	

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Center for Respiratory Health  
University of Illinois at Chicago

Respiratory Center (at UIC)

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6/14/83

*[Signature]*

830 University Ave, Chicago

11/1/83

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30506

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EDNA M. BURNS</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>11/12/83</b>	
2b. HOUR <b>5:35 AM</b>			
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>June 10, 1898</b>	6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <b>85</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>	7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY Co., MD.</b>
10. CITY OR TOWN OF DEATH <b>Bethesda</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>	12a. USUAL OCCUPATION (WORKING LIFE) <b>Photographic Supervisor</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Eastman Kodak</b>
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Bethesda</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Hutchinson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Murray</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b. SOCIAL SECURITY NO. <b>073-09-6854</b>	17. INFORMANT ADDRESS <b>Clinton F. Burns Husband Same as 13c</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>5990 Sepsis</b> IMMEDIATE CAUSE (a) <b>Due to, or as a consequence of</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Urinary Tract Infection</b> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) <b>2 days</b> <b>2 weeks</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Malnutrition, Hypertension</b>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <b>11-11-83</b> to <b>11-12-83</b> , that (I) (we) last saw the deceased alive on <b>11-11-83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			
22b. SIGNATURE <b>John S. Saita</b>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>11/13/83</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. S. SAITA</b>	22e. ADDRESS <b>809 Uiers Mill Rd Rock Md</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>	23b. DATE <b>Nov. 13, 1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria Virginia</b>
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1983</b>	
P.A., Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE <b>John J. Connelley</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ARTHUR NORRIS BUTLER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 17 1983</b>		2b. HOUR <b>11:45 AM</b>	
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JULY 6 1929</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>TENNESSEE</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.				
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>U.S.M.C.</b>		13a. STATE <b>MARYLAND</b>				
13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>JEWEL B. BUTLER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SARAH KATHLEEN GREER</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1946-1977</b>		17. INFORMANT ADDRESS <b>DOROTHY R. BUTLER, 11811 NEW HAMPSHIRE AVENUE</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SMALL CELL CARCINOMA OF LUNG</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 7</b> , 19 <b>83</b> , to <b>NOVEMBER 17</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>NOVEMBER 17</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Michael D. Canty</i>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>17 Nov 83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MICHAEL D. CANTY, LT, MC, USNR</b>		22e. ADDRESS <b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/21/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Cemetery</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington, Va.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Hines/Rinaldi Funeral Home S.S.Md.</b>				
25. DATE <b>NOV 22 1983</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Canine</i>				

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Handwritten notes and calculations, including a table with columns for 'Date', 'Description', and 'Amount'. The text is mostly illegible due to fading.

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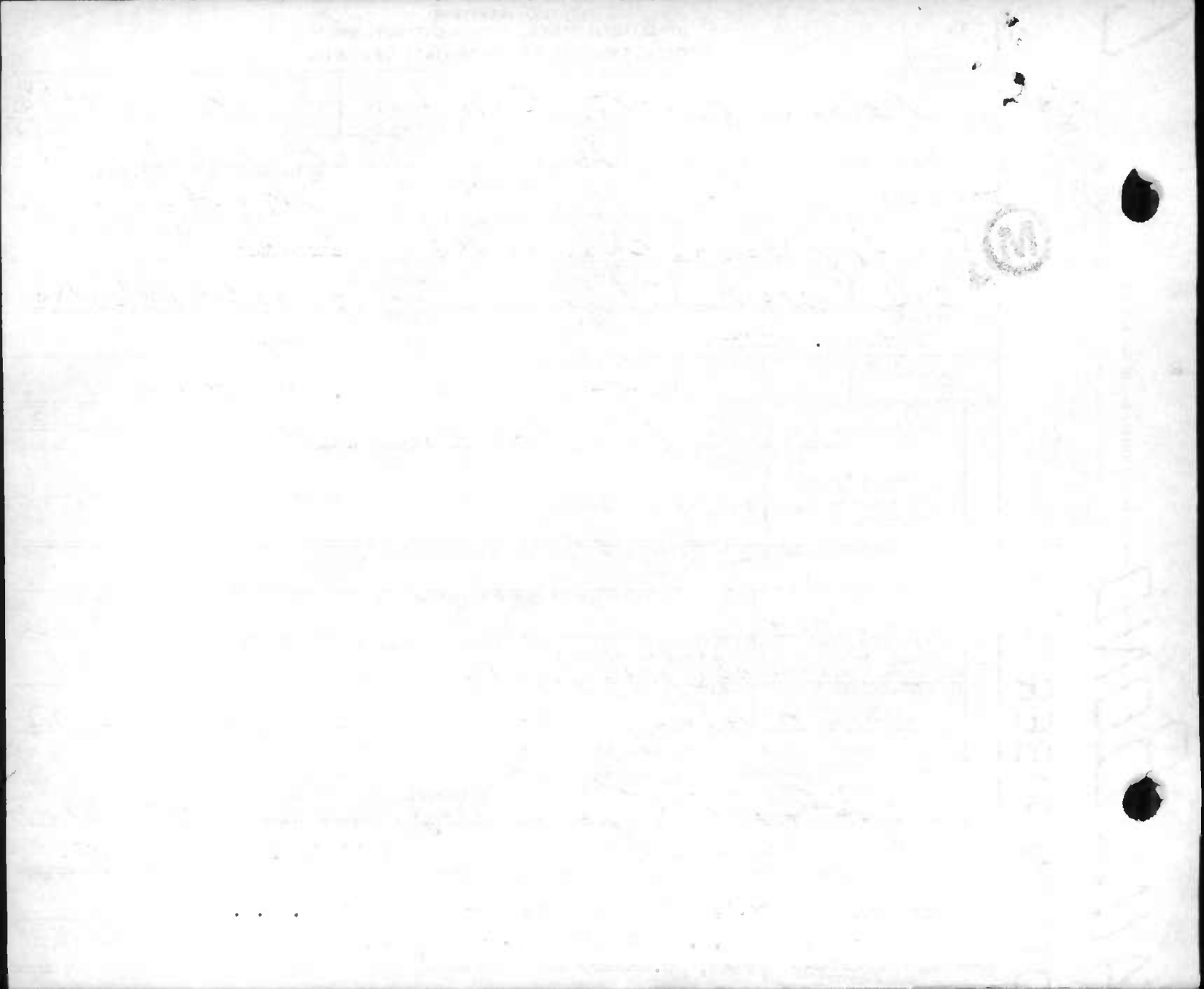
Handwritten notes and calculations, including a table with columns for 'Date', 'Description', and 'Amount'. The text is mostly illegible due to fading.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										30508 REG. NO.			
1- STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Roland Robert Callihan</i>										2a. DATE KNOWN OF DEATH MONTH DAY YEAR <i>Nov. 30, 1983</i>		2b. HOUR <i>3:38 PM</i>	
3. SEX <i>M</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Aug 25, 57</i>		6. AGE (IN YEARS) LAST BIRTHDAY YRS. <i>26</i>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>Nov. 30, 1983</i>		7d. HOUR <i>3:38 PM</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Germany</i>				7b. CITIZEN OF WHAT COUNTRY? <i>U S A</i>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery MD.</i>			
CITY OR TOWN OF DEATH <i>541 Spg</i>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>12203 Charles Rd</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>carpenter</i>				12b. KIND OF BUSINESS OR INDUSTRY	
13a. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <i>MD</i>				13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Silver Spg</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>12203 Charles Rd</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles O. Callihan</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Elizabeth Weymar</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>no</i>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>218-76-4974</i>		17. INFORMANT ADDRESS <i>Charles O. Callihan(father)</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gunshot Wound to Chest</i> <i>9554</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION <i>None</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>300 M 1130 1983</i>				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>1130 1983</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>shot self</i>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) <i>Home</i>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>Charles Rd Silver Spg Mont MD</i>					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>John S. Rogers</i>				TITLE (SPECIFY) <i>MD.</i>				MEDICAL EXAMINER <i>1919 Seminary Rd. S.S. Md.</i>				DATE SIGNED <i>Nov 30 1983</i>	
EXAMINER'S NAME (TYPE OR PRINT) <i>John S. Rogers</i>				ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>cremation</i>				23b. DATE <i>Dec 1, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lee Crematory</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Wash. D.C.</i>			
24. FUNERAL DIRECTOR NAME <i>Hines/Rinaldi F.H.</i>						ADDRESS <i>11800 New Hamp. Ave</i>				25a. DATE REC'D. BY REGISTRAR <i>DEC 5 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John S. Rogers</i>	
Silver Spring, Md.													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Christopher J. Campbell</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-30-83</b>		2b. HOUR <b>12:30<sup>AM</sup></b>		
3. SEX <b>Male</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6-3-08</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>75</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery Co.</b> MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ins. Mgr.</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE <b>PA</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Ardmore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Christopher Campbell</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lydia Willeman</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>081-03-8175</b>		17. INFORMANT <b>Mary Campbell</b>		ADDRESS <b>same as #13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4100</b> <b>cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Brain damage - ischemic 1 day</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>myocardial infarct</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11/28</b> , 19 <b>83</b> , to <b>11/30</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>11/29</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Richard P. Delaney MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Richard P. Delaney MD</b>				22e. ADDRESS <b>4323 Howard St. St. Louis 2094</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>DEC 3, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Springfield Delaware Co PA</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>William J. O'Say 640 E. Springfield Rd. SPRINGFIELD, PENNA. 19084</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 6 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canfield</b>	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>VIEVA M. CARMICHAEL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-21-83</b>		2b. HOUR <b>11:28 P.M.</b>		
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb 1 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Oklahoma</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Broker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JACOB B. MOFFET</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Millie nmw Waychoff</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>448-32-587</b>		17. INFORMANT <b>Mr. John Pate 710 Wilson Ave. Rockville Md.</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **cerebrovascular accident**

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Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**1 mo.**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

**congestive heart failure; renal insufficiency**

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED  
WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from **11/10**, 19 **80**, to **11/21**, 19 **83**, that (I) (we) lost saw the deceased alive on **11/21**, 19 **83**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

**Sanford N. Richman, M.D.**

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS  
**11500 Old Georgetown Rd, Rockville, MD 20852**ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 28, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland PG Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>W.W. Chambers Co. 8655 Ga. Ave., Silver Spring</b>				25a. DATE REGD. BY REGISTRAR <b>NOV 30 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Givens</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with Item 72.

with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed, within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 3 3 0 5 1 1			
1. DECEASED NAME (TYPE OR PRINT) <b>Filomene C. Carrera</b>				2a. DATE OF DEATH MONTH <b>11</b> - DAY <b>9</b> - YEAR <b>83</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH <b>April</b> DAY <b>16</b> YEAR <b>1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Italy</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>	
14. FATHER'S NAME FIRST <b>Antonio</b> MIDDLE <b>Castellano</b> LAST <b>Castellano</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Rosa</b> MIDDLE <b>Ventrella</b> LAST <b>Ventrella</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>578-05-7292</b>		17. INFORMANT ADDRESS <b>Vincent Carrera, Sr. Husband Same as 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiovascular collapse</b> <b>4410</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>acute dissecting aortic aneurysm</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>and pericardial tamponade</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11/04</b> , 19 <b>83</b> , to <b>11/09</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>11/08</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Joseph Szalinas</b> MD DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/09/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOSEPH SZALINAS</b>				22e. ADDRESS <b>9901 GEO. AVE. SS MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 12, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland Pr. Geo. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b> ADDRESS <b>500 University Blvd., W. Silver Spring, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 17 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conish</b>	

BP

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.



*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]*

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(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 3 3 3 0 5 1 2			
FOR Item 13e 11-23-83 cn							
1- STATE REGISTRAR NAOMA A. CHALMERS							
1. DECEASED NAME (TYPE OR PRINT) <b>NAOMA A. CHALMERS</b>				2a. DATE OF DEATH MONTH DAY YEAR 10 21 83			
3. SEX FEMALE				5. DATE OF BIRTH MONTH DAY YEAR MAY 8, 1895			
7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
10. CITY OR TOWN OF DEATH ROCKVILLE				9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY, MD.			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL LUTHERAN HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BOOKKEEPER			
13a. STATE MARYLAND				13e. STREET ADDRESS 1008 21212 -10008 EAST LAKE AVENUE			
14. FATHER'S NAME FIRST MIDDLE LAST AUGUSTUS DUBS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LAURA E. CRAMER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				17. INFORMANT ADDRESS REV. RICHARD REICHARD 9701 Veirs Dr. Rockville Md.			
16b. SOCIAL SECURITY NO. 212-05-2289				17. INFORMANT ADDRESS REV. RICHARD REICHARD 9701 Veirs Dr. Rockville Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>#8 HD</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Feb. 26, 1982, to Oct. 21, 1983, that (I) (we) lost saw the deceased alive on Oct. 21, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE <i>Thomas E. Dooley</i>				DEGREE		22c. DATE SIGNED 10/21/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas E. Dooley, M.D.				22e. ADDRESS 17904 Georgia Ave. Olney, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Oct. 24, 1983		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland							
24. FUNERAL DIRECTOR NAME The Hysong Company				25a. DATE REC'D. BY REGISTRAR 8 1983		25b. REGISTRAR'S SIGNATURE <i>Samuel C. ...</i>	

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30513

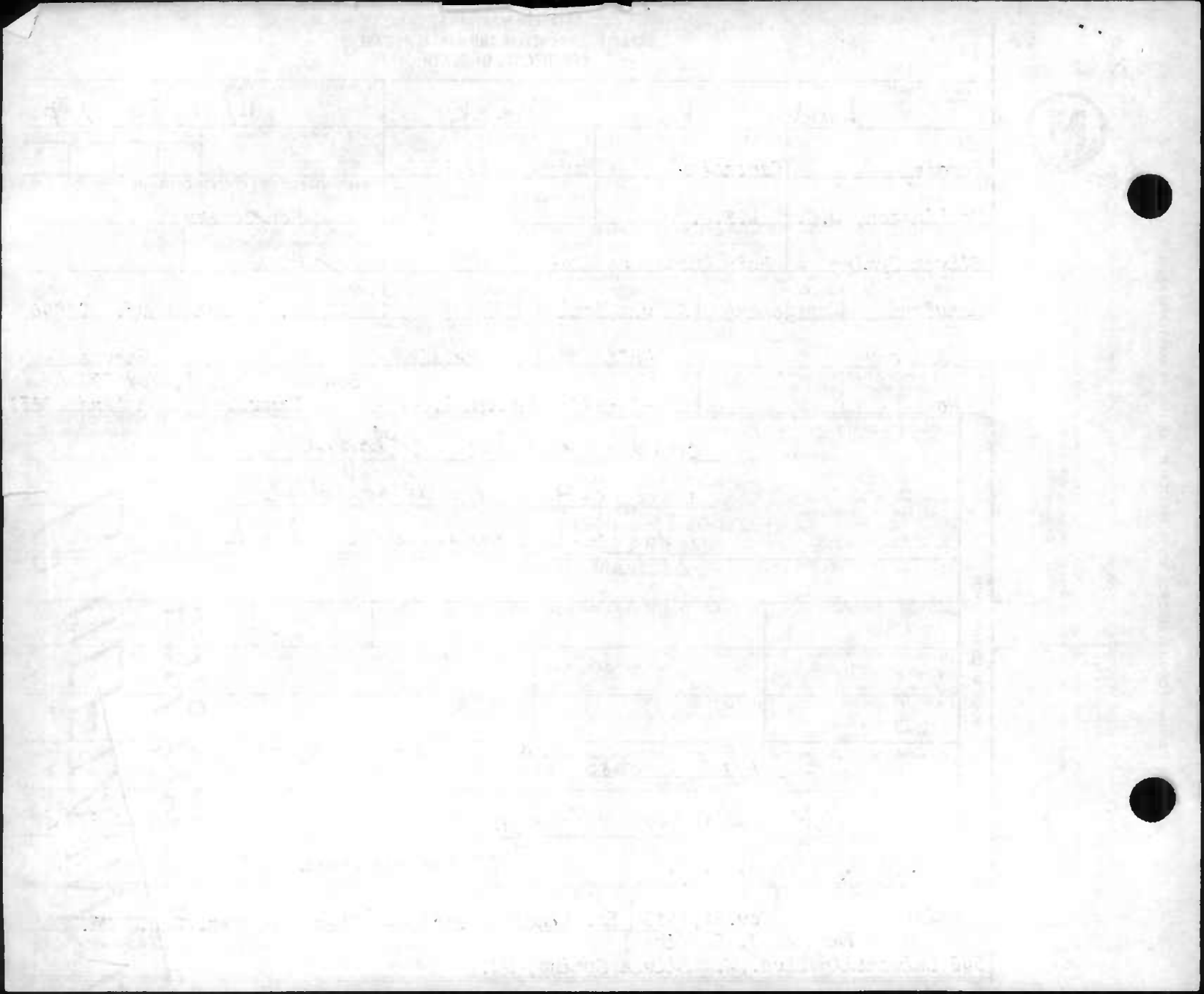
1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Linda R. Check			2a. DATE OF DEATH MONTH DAY YEAR 11/25/83		2b. HOUR 7:30 PM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR November 27, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Anthony		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Graves		17. INFORMANT Son Rt. 1, Box 378 A Bryantown, Maryland 20617	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-40-6901		17. INFORMANT Warren L. Cheek	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiovascular collapse</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute, extensive myocardial</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>infarction - cardiogenic shock</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/10</u> , 19 <u>83</u> , to <u>11/25</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>11/25</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J. M. Solinas		DEGREE MD		22c. DATE SIGNED 11/26/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph M. Solinas, M. D.		22e. ADDRESS 9801 Georgia Avenue Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE Nov. 28, 1983		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	
24. FUNERAL DIRECTOR NAME Francis J. Collins		ADDRESS 500 University Blvd., W. Silver Spring, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.	
25a. DATE REC'D BY REGISTRAR DEC 2 1983		25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. If the death is not reported to the hospital or attending physician, the certificate should be filed within 72 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Medical examiner notified and released  
MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 30514	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>William Wai Lung Chow</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 3, 1983</b>		2b. HOUR <b>10:39pm</b>
3. SEX <b>Male</b>	4. RACE <b>Oriental</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>June 24, 1944</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>39</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Canton, China</b>	7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Part owner</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Silver Spring</b>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>King Yen Chow</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Tong Choi Tong</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>578-76-7617</b>		17. INFORMANT ADDRESS <b>Ching Mei Chow (Wife) Same as #13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardio-pulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>due to hepatoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>1550</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>April 23, 1975</b> to <b>Nov 2, 1983</b> , that (I) (we) lost saw the deceased alive on <b>Nov 2, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Sando K. Irani</i>				22c. DATE SIGNED <b>Nov. 4, 1983</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Sando K. Irani, MD</b>				22e. ADDRESS <b>916-19th St., NW, Washington, DC</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 9, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cem.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring, Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>J.Wm. Lee's Sons Co.</b>		24a. ADDRESS <b>300-4th St., NE, Wash.</b>		24b. REC'D. BY REGISTRAR STRAR'S SIGNATURE <i>J. Wm. Lee's Sons Co.</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30515

1. DECEASED NAME (TYPE OR PRINT) Benjamin Harvey Clark			2a. DATE OF DEATH MONTH DAY YEAR 11 4 83			2b. HOUR 4:50 P.M.					
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Feb., 7-1884		6. AGE (IN YEARS LAST BIRTHDAY) 99		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Minister		12b. KIND OF BUSINESS OR INDUSTRY Unitarian Ch.			
13a. STATE Md.			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Sp.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3351 Hewitt Ave 20906		
14. FATHER'S NAME FIRST MIDDLE LAST John Richard Clark				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST M.A. Burnett							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO (IF YES, GIVE YEAR OR DATES) WW I Army 297-34-5824		17. INFORMANT ADDRESS 20906 Allen Clark-son 3351 Hewitt Ave Sil.Sp., Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Respiratory arrest</u> 4860 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia, Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Semility</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>10/22</u> , 19 <u>83</u> , to <u>11/4</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>11/31</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Tony P. Kannarkat						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TONY P. KANNARKAT						22e. ADDRESS 8201 16th St S.S MD 20910					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 5 November		23c. NAME OF CEMETERY OR CREMATORY 1983 Lee's Crematory			23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. 20002			
24. FUNERAL DIRECTOR NAME Lee Funeral Home 300-4th Street N.E. Wash.D.						25a. DATE REC'D. BY REGISTRAR NOV 14 1983		25b. REGISTRAR'S SIGNATURE James G. Carter			

1 *John Smith* 1892 1893. . . . . 1894 1895 1896 1897 1898 1899 1900 1901 1902 1903 1904 1905 1906 1907 1908 1909 1910 1911 1912 1913 1914 1915 1916 1917 1918 1919 1920 1921 1922 1923 1924 1925 1926 1927 1928 1929 1930 1931 1932 1933 1934 1935 1936 1937 1938 1939 1940 1941 1942 1943 1944 1945 1946 1947 1948 1949 1950 1951 1952 1953 1954 1955 1956 1957 1958 1959 1960 1961 1962 1963 1964 1965 1966 1967 1968 1969 1970 1971 1972 1973 1974 1975 1976 1977 1978 1979 1980 1981 1982 1983 1984 1985 1986 1987 1988 1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348 2349 2350 2351 2352 2353 2354 2355 2356 2357 2358 2359 2360 2361 2362 2363 2364 2365 2366 2367 2368 2369 2370 2371 2372 2373 2374 2375 2376 2377 2378 2379 2380 2381 2382 2383 2384 2385 2386 2387 2388 2389 2390 2391 2392 2393 2394 2395 2396 2397 2398 2399 2400 2401 2402 2403 2404 2405 2406 2407 2408 2409 2410 2411 2412 2413 2414 2415 2416 2417 2418 2419 2420 2421 2422 2423 2424 2425 2426 2427 2428 2429 2430 2431 2432 2433 2434 2435 2436 2437 2438 2439 2440 2441 2442 2443 2444 2445 2446 2447 2448 2449 2450 2451 2452 2453 2454 2455 2456 2457 2458 2459 2460 2461 2462 2463 2464 2465 2466 2467 2468 2469 2470 2471 2472 2473 2474 2475 2476 2477 2478 2479 2480 2481 2482 2483 2484 2485 2486 2487 2488 2489 2490 2491 2492 2493 2494 2495 2496 2497 2498 2499 2500 2501 2502 2503 2504 2505 2506 2507 2508 2509 2510 2511 2512 2513 2514 2515 2516 2517 2518 2519 2520 2521 2522 2523 2524 2525 2526 2527 2528 2529 2530 2531 2532 2533 2534 2535 2536 2537 2538 2539 2540 2541 2542 2543 2544 2545 2546 2547 2548 2549 2550 2551 2552 2553 2554 2555 2556 2557 2558 2559 2560 2561 2562 2563 2564 2565 2566 2567 2568 2569 2570 2571 2572 2573 2574 2575 2576 2577 2578 2579 2580 2581 2582 2583 2584 2585 2586 2587 2588 2589 2590 2591 2592 2593 2594 2595 2596 2597 2598 2599 2600 2601 2602 2603 2604 2605 2606 2607 2608 2609 2610 2611 2612 2613 2614 2615 2616 2617 2618 2619 2620 2621 2622 2623 2624 2625 2626 2627 2628 2629 2630 2631 2632 2633 2634 2635 2636 2637 2638 2639 2640 2641 2642 2643 2644 2645 2646 2647 2648 2649 2650 2651 2652 2653 2654 2655 2656 2657 2658 2659 2660 2661 2662 2663 2664 2665 2666 2667 2668 2669 2670 2671 2672 2673 2674 2675 2676 2677 2678 2679 2680 2681 2682 2683 2684 2685 2686 2687 2688 2689 2690 2691 2692 2693 2694 2695 2696 2697 2698 2699 2700 2701 2702 2703 2704 2705 2706 2707

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

3 0 5 1 6

1. FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
**JAMES L. CLARK**

2a. DATE OF DEATH MONTH DAY YEAR  
**11 11 83**

2b. HOUR  
**2:30 A**

3. SEX  
**Male**

4. RACE  
**White**

5. DATE OF BIRTH MONTH DAY YEAR  
**8/30/20**

6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.  
**63**

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
**Maryland**

7b. CITIZEN OF WHAT COUNTRY?  
**USA**

8. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH  
**Montgomery** MD.

10. CITY OR TOWN OF DEATH  
**Bethesda**

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
**Suburban Hospital**

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
**retired**

12b. KIND OF BUSINESS OR INDUSTRY  
**Montgomery County**

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY 13d. CITY OR TOWN 13e. INSIDE CITY LIMITS? YES ☒ NO ☐ 13f. STREET ADDRESS  
**Maryland Montgomery Silver Spring 1131 University Blvd. W. #1809**

14. FATHER'S NAME FIRST MIDDLE LAST  
**John Lesley Clark**

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
**Gertrude Colvin**

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) **Yes** 16b. SOCIAL SECURITY NO. **214-12-7602** 17. INFORMANT ADDRESS  
**Pauline C. Clark same as 13e**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:  
**1579 IMMEDIATE CAUSE (a) Pancreatic Carcinoma**

CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.  
(b) \_\_\_\_\_  
(c) \_\_\_\_\_

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) \_\_\_\_\_

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 19c. AUTOPSY? YES ☐ NO ☒ 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 **19** 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21a. INJURY OCCURRED 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21c. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from **19 79**, to **November 10 19 83**, that (I) (we) last saw the deceased alive on **November 11 19 83**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.

22b. SIGNATURE DEGREE **Daniel Rosenthal MD** ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED **11/11/83**

22d. PHYSICIAN'S NAME (TYPE OR PRINT) **DANIEL ROSENBLUM** 22e. ADDRESS **10400 CONNECTICUT AV KENSINGTON, MD 20895**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) **Burial** 23b. DATE **11/15/83** 23c. NAME OF CEMETERY OR CREMATORY **Quantico National Cemetery** 23d. LOCATION (CITY OR TOWN) STATE **Quantico, Virginia**

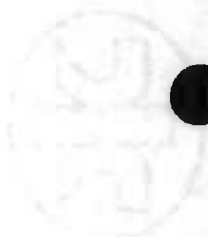
24. FUNERAL DIRECTOR **Lyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852** 25a. DATE REC'D. BY REGISTRAR **NOV 17 1983** 25b. REGISTRAR'S SIGNATURE **John J. Carver**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 14 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 308	17
1. DECEASED NAME (TYPE OR PRINT) <b>William B Clark</b>							2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <b>11</b> DAY <b>9</b> YEAR <b>1983</b>		2b. HOUR <b>4:20 PM</b>		
1a. SEX <b>M.</b>	4. RACE <b>W.</b>	5. DATE OF BIRTH MONTH <b>7</b> DAY <b>12</b> YEAR <b>36</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>47</b> RS.	IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>	IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	2c. DATE PRONOUNCED DEAD MONTH <b>11</b> DAY <b>9</b> YEAR <b>1983</b>		2d. HOUR <b>4:20 PM</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>FLORIDA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD.</b>				
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL BETHESDA</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>U.S. MARINE CORPS</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>BETHESDA</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Naval Hospital, Bethesda</b>			
14. FATHER'S NAME <b>WILLIAM F.</b>		15. MOTHER'S MAIDEN NAME <b>MARTHA DYE</b>		13f. HUSBAND NAMED COM - NATCAPREG -							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>MAY 58 - NOV 83 265-54-3302</b>		17. INFORMANT <b>PAT DUBOSE ENS, MSC, USN</b>				ADDRESS <b>NAVHOSP BETHESDA</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <b>Multiple injuries</b>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <b>Severe</b>											
(b) <b></b>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <b></b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>4:00 PM NOV 9 1983</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>FELL/JUMPED? FROM PARKING GARAGE</b>							
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>NAVHOSP BETHESDA</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>NAVAL HOSPITAL BETHESDA MONTGOMERY MD</b>							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>John Lauber</b>		TITLE (SPECIFY) <b></b>		M.D. <b></b>		MEDICAL EXAMINER <b></b>		DATE SIGNED <b>11-9-83</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>John Lauber</b>		ADDRESS <b>8218 Wisconsin Ave.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-16-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington, Va.</b>					
24. FUNERAL DIRECTOR <b>Marshall's Funeral Home</b>		ADDRESS <b>4217 9th St. NW: Washington, D.C.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 17 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Lauber</b>					

1961-1962  
1961-1962

1961-1962

1961-1962

1961-1962

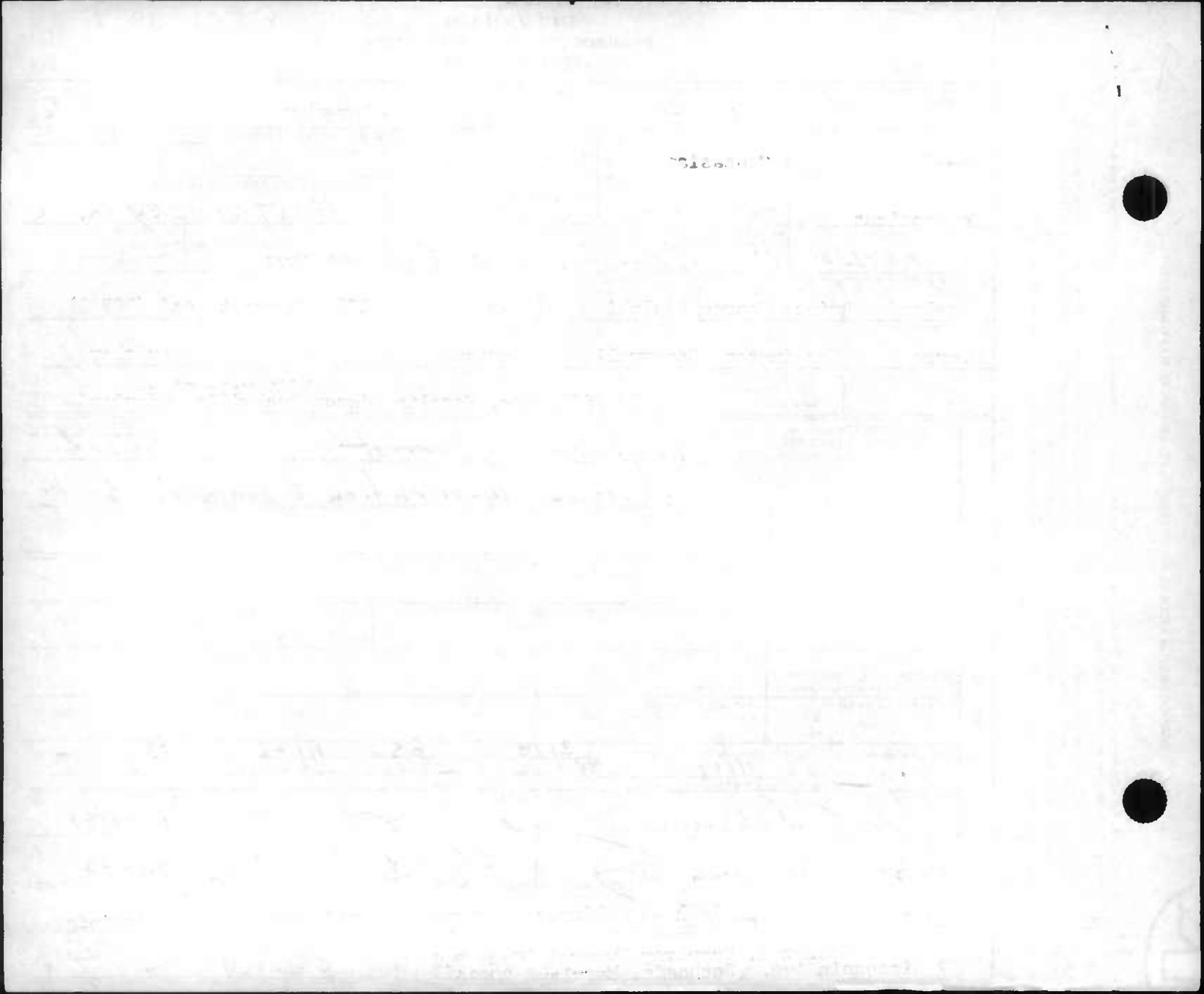
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death. This certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death. with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>MILDRED H. CLARKE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 22, 1983</b>		2b. HOUR <b>11 A.M.</b>
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>February 5, 1895</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Connecticut</b>	7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY Co. MD.</b>		
10. CITY OR TOWN OF DEATH <b>ROCKVILLE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>COLLINGSWOOD Nsg. Ctr.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Prince George</b>	13c. CITY OR TOWN <b>Adelphi</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Washington Cogswell</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marian Beardsley</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>215-58-7622</b>	17. INFORMANT ADDRESS <b>Mrs. Natalie Gibson 1681 Yale Place Rockville, Maryland 20850</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic aspiration - pneumonia 6 wks</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>5070</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immed</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>3/18</b> , 19 <b>83</b> , to <b>11/22</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>11/19</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (if (we) did) (did not) view the body after death.					
22b. SIGNATURE <b>Robert Millman</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/22/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert Millman, MD</b>		22e. ADDRESS <b>1515 Dec Park Dr Gaithersburg Md 20877</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>November 28 1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington Virginia</b>	25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1983</b>	
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>		25c. REGISTRAR'S NAME <b>John J. Conner</b>	
7557 Wisconsin Ave. Bethesda, Maryland 20814					





STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

30519

 1. FOR  
 STATE  
 REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SAMUEL BENJAMIN CLEM, JR.			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 13, 1983		2b. HOUR 1:55 p.m.			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 29, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.		
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CLINICAL CENTER, NIH, BETH. MD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner, Ret.		12b. KIND OF BUSINESS OR INDUSTRY Sporting Goods		
13a. STATE VIRGINIA			13b. COUNTY SHENANDOAH		13c. CITY OR TOWN WOODSTOCK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel B. Clem, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Good		13e. STREET ADDRESS 559 WEST SPRING STREET 22664			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 227-09-3281		17. INFORMANT ADDRESS FRANKIE CLEM (WIFE) SAME AS PATIENT				

 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
 PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory failure due to pneumonitis withDUE TO, OR AS A CONSEQUENCE OF bilateral hemorrhagic change.(b) Diffuse histiocytic lymphoma.

DUE TO, OR AS A CONSEQUENCE OF

(c)

 Conditions, if any, which  
 gave rise to immediate  
 cause (a), stating the  
 underlying cause last.
APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>October 28, 1983</u> , to <u>November 13, 1983</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>November 13, 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death.							
22b. SIGNATURE <u>Eugenia Legan MD</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>11/14/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENIA LEGAN, MD.				22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA MD 20205			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-16-83		23c. NAME OF CEMETERY OR CREMATORY Sunset View Memorial Gardens, Woodstock, Shen., Va.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Vernon Heishman				ADDRESS Woodstock, Virginia			

NOV 18 1983

John J. Carver



517-00-1261



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NOV 18 1953

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30520

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Flora HIRSCHMAN Cohen</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 7, 1983</b>			2b. HOUR <b>7:15P M</b>					
3. SEX <b>female</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 05 01</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>81</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.		
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE WORK FOR IN LAST WORKING LIFE) <b>HOUSEWIFE</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>MONTGOMERY</b>			13c. CITY OR TOWN <b>SILVER SPRING</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME <b>JOSEPH</b>			15. MOTHER'S MAIDEN NAME <b>ESTHER SHAPIRO</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO <input checked="" type="checkbox"/> NO <input type="checkbox"/> (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO. <b>219-48 3399</b>		
17. INFORMANT <b>JOANNE COHEN</b>			18. ADDRESS <b>400 KIMBLEWICK DRIVE SILVER SPRING, MARYLAND</b>			19. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			22a. I certify that (I) (this hospital) attended the deceased from <b>10/4/83</b> , 19 <b>73</b> , to <b>11-07</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>11-07</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE <b>Robert Kramer</b> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22c. DATE SIGNED <b>11-07-83</b>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT KRAMER</b>			22e. ADDRESS <b>10313 GEORGETOWN AVE SILVER SPRING MD 2090</b>			23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		
23b. DATE <b>11/9/1983</b>			23c. NAME OF CEMETERY OR CREMATORY <b>MOUNT LEBANON CEMETERY</b>			23d. LOCATION CITY OR TOWN COUNTY <b>ADELPHI, GEORGETOWN, MARYLAND</b>			24. FUNERAL DIRECTOR <b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME.</b>		
24. FUNERAL DIRECTOR <b>232 CARROLL STREET, N. W., WASHINGTON, D. C.</b>			25. DATE REC'D. BY REGISTRAR <b>NOV 14 1983</b>			26. REGISTRAR'S SIGNATURE <b>Joan G. Grier</b>					

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**CONGESTIVE HEART FAILURE**

4409  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **MITRIOSCLENOSIS**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

**Pleural EFFUSION - ADENOCARCINOMA**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 172 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
MARITA COLCAIRE			11 11 19 83			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7. DATE PRONOUNCED DEAD	2d. HOUR	
Female	White	7 18 39	44 YRS.	MONTHS	DAYS	11 11 19 83	6:35 P M	
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			8b. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH		
West Germany			United States			Montgomery County MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
			Cabin John Pkwy. & McArthur Blvd.			Sales person		
12b. KIND OF BUSINESS OR INDUSTRY			13a. INSIDE CITY LIMITS?			13b. STREET ADDRESS		
Apparel			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			7004 Buxton Terrace (20817)		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.		
Peter			Maria			231-68-9460		
17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Paul J. Colcaire, same as #13			PART I DEATH WAS CAUSED BY:					
			IMMEDIATE CAUSE (a) Multiple injuries					
			DUE TO, OR AS A CONSEQUENCE OF					
			(b)					
			DUE TO, OR AS A CONSEQUENCE OF					
			(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
			P.M. 11-11- 19 83			Subject jumped from overpass.		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION		
			overpass			Cabin John Pkwy. & McArthur Blvd., Mont., Md.		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
Ann M. Dixon, M.D.			M.D. Assistant MEDICAL EXAMINER			11-12-83		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			111 Penn St., Balto., Md. 21201		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
Cremation			11-17-83			Metropolitan Crematory		
23d. LOCATION			23e. DATE REC'D BY REGISTRAR			23f. REGISTRAR'S SIGNATURE		
Alexandria			NOV 16 1983			John J. Gough		
24. FUNERAL DIRECTOR			24a. NAME			24b. ADDRESS		
Robert A. Pumphrey Funeral Homes, P.A.			Bethesda, Md.					

BP

W/SP

10/1/54



0-4-50-1-52



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30522

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Abraham Edward Coleman		2a. DATE OF DEATH MONTH DAY YEAR 11/22/83		2b. HOUR 8 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 12 1892		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 91	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney		12b. KIND OF BUSINESS OR INDUSTRY Self	
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Mathias Coleman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hannah Alexander		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 168 30 6550	
17. INFORMANT ADDRESS Harris E. Coleman (Son) same as 13E							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>coronary artery disease</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. 4149							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>massive pneumonia</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11-20-1983</u> to <u>11-22-1983</u> , that (I) (we) last saw the deceased alive on <u>11-22-1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE H. Bator		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-23-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HADI BAHAR		22e. ADDRESS 8218 Wisconsin Ave. Beth.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/25/83		23c. NAME OF CEMETERY OR CREMATORY Beth El Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Allentown, Pa.	
24. FUNERAL DIRECTOR NAME Hines/Rinaldi 11800 New Hampshire Ave. S.S. Md.				25a. DATE REC'D. BY REGISTRAR NOV 23 1983		25b. REGISTRAR'S SIGNATURE John J. Lohr	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF NEW YORK  
IN SENATE  
January 10, 1907.

REPORT  
OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 1, 1906.

ALBANY:  
J. B. LIPPINCOTT & COMPANY, PRINTERS.  
1907.



RELEASED BY DR. WATSON M.E. 11/21/83

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 5 2 3

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOHN Patrick COLLINS, Sr.			2a. DATE OF DEATH MONTH DAY YEAR 11-20-83			2b. HOUR 12 45 PM			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 10, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman		12b. KIND OF BUSINESS OR INDUSTRY Terminal Co.	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10207 Portland Road 20901	
14. FATHER'S NAME FIRST MIDDLE LAST Patrick J. Collins			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary A. Costello			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 718-14-9860			17. INFORMANT Marie A. Collins			17. ADDRESS Wife Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 7330 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Spontaneous fracture of leg (c) Osteoporosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from OCT 25, 1982 to 20 NOV 1983, that (b) we last saw the deceased alive on 19 83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (c) we (did) (did not) view the body after death.									
22b. SIGNATURE Walter E. Gooch MD						DEGREE MD		22c. DATE SIGNED 20 NOV 83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOOCH MD						22e. ADDRESS 2309 SHOREFIELD RD WHEATON MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 23, 1983		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Mont. Md.		
24. FUNERAL DIRECTOR NAME Francis J. Collins 500 University Blvd., W. Silver Spring, Md.						25a. DATE REC'D. BY REGISTRAR NOV 25 1983		25b. REGISTRAR'S SIGNATURE Francis J. Collins	

THE UNIVERSITY OF CHICAGO

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>LOUIS - COLMAN</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>11 - 2 - 83</b>		2b. HOUR <b>6:35 PM</b>			
3. SEX <b>MALE</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 17 96</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASH. D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Rockville, Md</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS) <b>Rockville Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SALES</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HARDWARE</b>			
13a. STATE <b>md</b>		13b. COUNTY <b>mtgy</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>11801 Rockville Pike</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>HARRY Colman</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ida Goldsmith</b>				ADDRESS <b>2304 ROSS ROAD</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO <b>579-44.0767</b>		17. INFORMANT <b>SHIRLEY C. GREENBAUM, SILVER SPRING, MARYLAND</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CVA</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>12/17/83</b> to <b>11/2/83</b> , that (I) (we) last saw the deceased alive on <b>11/2/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (I) did not) saw the body after death.											
22b. SIGNATURE <b>[Signature]</b>						DEGREE <b>PHYSICIAN</b>		22c. DATE SIGNED <b>11/2/83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Alan B. Cohen, M.D.</b>						22e. ADDRESS <b>15975 Conn. Ave. S-S. Md. 20906</b>					
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>11/4/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WASHINGTON HEBREW CONGREGATION MEMORIAL PARK</b>		23d. LOCATION <b>WASHINGTON, D. C.</b>					
24. FUNERAL DIRECTOR <b>DAVID M. STEIN HEBREW MEMORIAL FUNERAL HOME</b> <b>232 CARROLL STREET, N. W., WASHINGTON, D. C.</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 7 1983</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30525

REG. NO.

1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Ann MIDDLE Evelyn LAST Colvin			2a. DATE KNOWN OF DEATH ESTIMATED Nov. 7, 1983 MONTH DAY YEAR		2b. HOUR 3:12 P.M.
3. SEX F	4. RACE W	5. DATE OF BIRTH Jan 25, 1916 MONTH DAY YEAR	6. AGE 66 YRS	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
13a. STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST Samuel MIDDLE Ray LAST Scholes		15. MOTHER'S MAIDEN NAME FIRST Lois MIDDLE Boren LAST Boren			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 115-01-9266		17. INFORMANT ADDRESS Mr. Burton Colvin (Same as #13.)	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 429.1 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Robert L. Jones</i>		TITLE (SPECIFY) M.D. <i>Dr. Jones</i>		MEDICAL EXAMINER DATE SIGNED Nov. 7, 1983	
EXAMINER'S NAME (TYPE OR PRINT) Robert L. Jones		ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 11/8/83		23c. NAME OF CEMETERY OR CREMATORY	
24. FUNERAL DIRECTOR NAME Anatomy Board		ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR NOV 10 1983	
		25b. REGISTRAR'S SIGNATURE <i>John J. Connelley</i>			

Calvin

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State of New York

No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) <i>Beatrice Elizabeth Conley</i>				Nov 11, 1983 10 25 AM			
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>3 25 1906</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>77</i> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County</i> MD.	
10. CITY OR TOWN OF DEATH <i>Takoma Park, Md</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hosp. Inc.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Retired Beauty Shop Operator</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <i>D.C.</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Washington</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <i>Joseph</i> MIDDLE <i>M.</i> LAST <i>LINDNER</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Elizabeth</i> MIDDLE <i>-</i> LAST <i>KNOCHE</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>			
16b. SOCIAL SECURITY NO. <i>214-05-8663-B</i>		17. INFORMANT <i>William P. Conley</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Renal and Mesenteric Ischemia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>2nd to Cholesterol Emboli at 11-8-83 Anterior</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Renal and Mesenteric Ischemia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>2nd to Cholesterol Emboli at 11-8-83 Anterior</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i>		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None other than Atherosclerotic Occlusive Disease</i>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>11-7-</i> 19 <i>83</i> , to <i>11-11-</i> 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>11-11-</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Paul Darlington Kiernan M.D.</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>Nov-11-83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Paul Darlington Kiernan M.D.</i>		22e. ADDRESS <i>831 University Blvd East</i> <i>Ston Spring, Md</i> <i>20903</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>NOV 15 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>HILLCREST BURIAL PARK</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>CUMBERLAND ALLEGANY MD</i>	
24. FUNERAL DIRECTOR NAME <i>SILCOX-MERRITT FUNERAL SERVICE</i>		ADDRESS <i>CUMBERLAND MD</i>		25a. DATE REC'D. BY REGISTRAR <i>NOV 16 1983</i> REGISTRAR'S SIGNATURE <i>John J. Gansh</i>			

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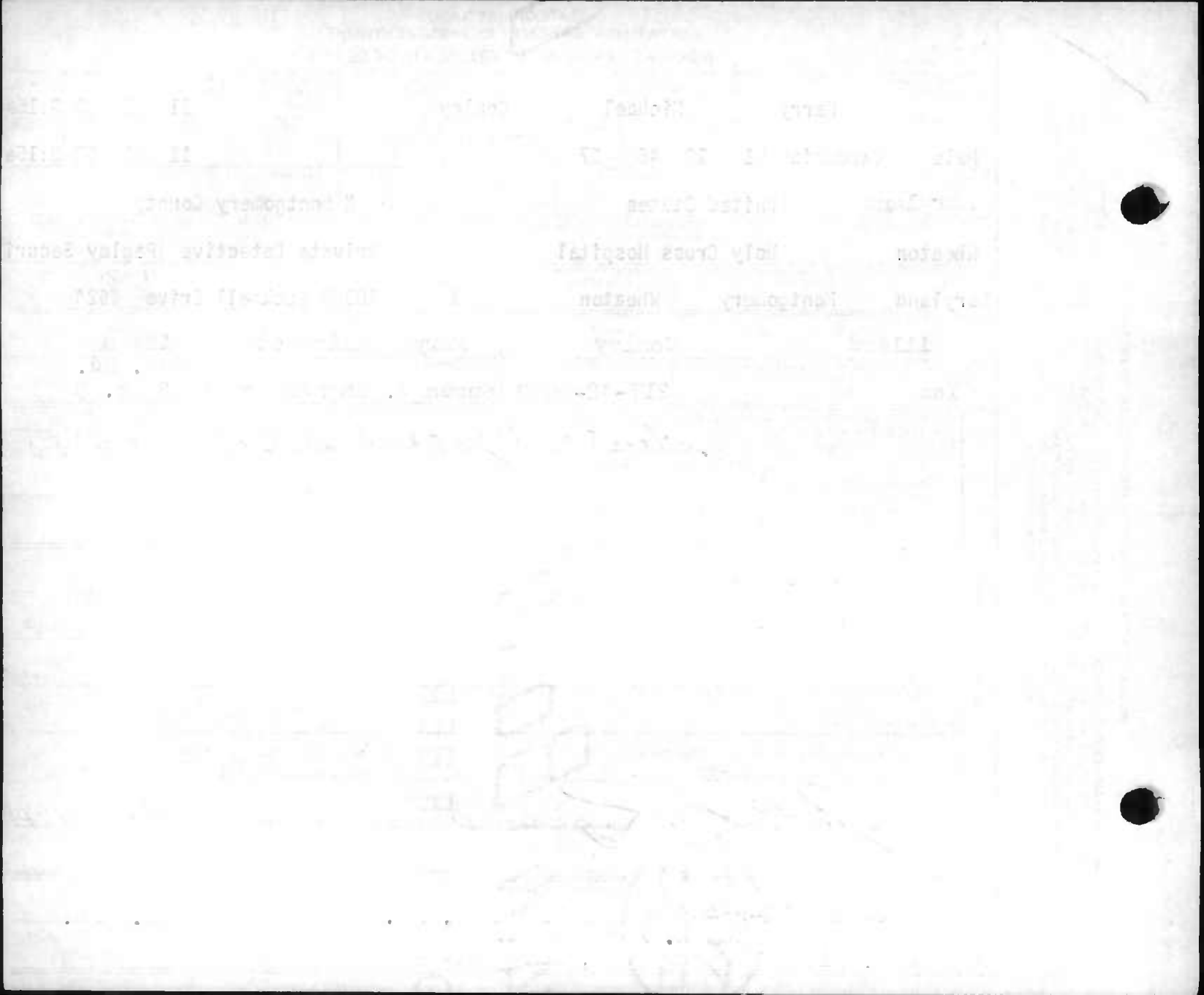
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 30527									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Harry Michael Conley</b>										2a. DATE KNOWN OF DEATH EST. MONTH DAY YEAR <b>11 21 19 83</b>		2b. HOUR <b>3:15a</b>							
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>01 18 46</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>37 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.									
10. CITY OR TOWN OF DEATH <b>Wheaton</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Private Detective</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Pagley Security</b>									
13a. STATE <b>Maryland</b>												13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Wheaton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>10900 Bucknell Drive #624</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Willard Conley</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Elizabeth Sixa</b>													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>217-42-9000</b>				17. INFORMANT ADDRESS <b>Susan E. Wagner Box 162B Rt. 9 Hag. Md.</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: <b>4291 Acute Myocardial Dis</b> IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 18. <b>None</b>																			
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>None</b>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <b>John L. Rogers</b> M.D.						TITLE (SPECIFY) <b>Dep.</b>			MEDICAL EXAMINER										
EXAMINER'S NAME (TYPE OR PRINT) <b>Gerald N. Minnich</b>						ADDRESS <b>305 N. Potomac St.</b>			DATE SIGNED <b>Nov. 21/1983</b>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>11-23-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn Mem. Pk.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown Wash. Md.</b>									
24. FUNERAL DIRECTOR NAME <b>Gerald N. Minnich</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1983</b>			25b. REGISTRAR'S SIGNATURE <b>John L. Conley</b>										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joan Marie Cooper						2a. DATE OF DEATH MONTH DAY YEAR 11 11 83			2b. HOUR 8:40 PM		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Dec. 12, 1928		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS			7. IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital Georgetown				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary			12b. KIND OF BUSINESS OR INDUSTRY Technical Engineering		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS (20852) 11915 Parklawn Drive #304			
14. FATHER'S NAME FIRST MIDDLE LAST John Fitchett				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lavinia Fagen							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 091-22-0947		17. INFORMANT ADDRESS Stephen J. Cooper, same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cancer of the lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1629 PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u></u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 days 7 months	
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION 9/28/83, 9/30/83			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Mediastinotomy, Bone Biopsy, etc.			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 20</u> , 19 <u>83</u> , to <u>11-11</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>11-11</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE J. D. Herman M.D.			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11-12-83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John D. Herman M.D.						22e. ADDRESS 4425 Montgomery Rd. Bz Thmda, Md 20811					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 16, 1983		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland				
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland						25a. DATE REC'D. BY REGISTRAR NOV 14 1983		25b. REGISTRAR'S SIGNATURE John J. Lohmeyer			

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*[Faint, mostly illegible handwritten text, possibly a letter or report, covering the majority of the page.]*



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>JOHN SANTON COSTELLO</b>				2a. DATE OF DEATH MONTH <b>11</b> DAY <b>12</b> YEAR <b>83</b>				2b. HOUR <b>2 P M</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>1</b> DAY <b>21</b> YEAR <b>15</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Massachusetts</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Tax Law Spec.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>I.R.S.</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>J.</b> LAST <b>Costello</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b></b> LAST <b>Stanton</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b> (IF YES, GIVE WAR OR DATES) <b>1942-66</b>			
16b. SOCIAL SECURITY NO. <b>577-22-8877</b>				17. INFORMANT <b>Carolyn M. McClay</b>		ADDRESS <b>211 Normandy Drive</b>		17b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4360 IMMEDIATE CAUSE (a) RESPIRATORY ARREST</b>				DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASPIRATION</b>		DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>ASPIRATION, CEREBROVASCULAR ACCIDENT IN PAST,</b>									
19a. DATE OF OPERATION <b>11-12-83</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b></b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b></b>		21f. LOCATION STREET <b></b>		CITY OR TOWN <b></b>		COUNTY <b></b> STATE <b></b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>11-10</b> 19 <b>83</b> to <b>11-12</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>11-12</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Mattinen MD</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/12/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MANGAL KATIKINENI</b>				22e. ADDRESS <b>3301 NEW MEXICO AVE NW #328 WASH. D.C. 20016</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 16, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Suitland Pr. Geo. Md.</b>		COUNTY <b></b> STATE <b></b>	
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b>				ADDRESS <b>500 University Blvd. W. Silver Spring, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 17 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Givich</b>	

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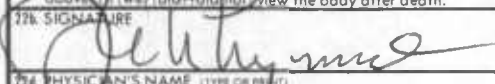

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>Charles M. Council Jr.</b>				2a. DATE OF DEATH MONTH <b>November</b> DAY <b>1</b> YEAR <b>1983</b>		2b. HOUR <b>8:00</b> AM <input type="checkbox"/> PM <input checked="" type="checkbox"/>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>April</b> DAY <b>12</b> YEAR <b>1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>GA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>7409 Fairfax Rd.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Realtor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>			
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>7409 Fairfax Rd.</b> <b>20814</b>			
14. FATHER'S NAME FIRST <b>Charles</b> MIDDLE <b>M.</b> LAST <b>Council</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Eula</b> MIDDLE <b>Willingham</b> LAST <b>Willingham</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>WW II</b>		17. INFORMANT <b>Eula C. Cureton</b>		ADDRESS <b>12 N. Church St. Westminster Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac arrest</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immed</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4100 } DUE TO, OR AS A CONSEQUENCE OF (b) <b>myocardial infarction</b>										24 hrs	
DUE TO, OR AS A CONSEQUENCE OF (c) <b>arterio-sclerotic heart disease</b>										20 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>hypertension</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>21 May</b> , 19 <b>87</b> , to <b>1 Nov</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>17 Oct</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE 				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11/2/83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John Wyman M. D.</b>				22e. ADDRESS <b>7801 Norfolk Ave. Bethesda, Md. 20814</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/5/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Suitland, Md.</b> COUNTY STATE					
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b> NAME <b>5130 Wisc. Ave. N.W. Wash., D.C. 20016</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 9 1983</b>		25b. REGISTRAR'S SIGNATURE 			

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REG. NO.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			13e. STREET ADDRESS 11442 Lockwood Drive, #201
14. FATHER'S NAME Harry V. Cover.		15. MOTHER'S MAIDEN NAME Ida Deaver	
		7931 Edgewood Farm Rd.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No.	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-14-5202	17. INFORMANT Mary Eliz. Robinson. Daughter.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:		
4291	IMMEDIATE CAUSE (a) <u>Acute myocardial disease.</u>	
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u>	(a) _____ DUE TO, OR AS A CONSEQUENCE OF	
	(b) _____ DUE TO, OR AS A CONSEQUENCE OF	
	(c) _____	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

None

MEDICAL CERTIFICATE	19a. DATE OF OPERATION <b>None</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
	21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>None</b>	
	21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22b. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE John S. Rogers TITLE (SPECIFY) Deputy DATE SIGNED 11/18/83  
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D. ADDRESS 1919 Seminary Road  
Silver Spring, Montgomery, Md.

23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial.	23b. DATE Nov. 21, 1983	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	23d. LOCATION City or Town Frederick	COUNTY Md.	STATE
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GENERAL DIRECTOR  
 ADDRESS  
 Takoma Funeral Home.  
 254 Carroll St. N. W. D. C. 22 1983  
 DATE REC'D. BY REGISTRAR  
 REGISTRAR'S SIGNATURE  
 John J. Carver

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR MUST BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 20100 PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JOHN ROBERT COWAN</b>			7a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>11 25 1983</b>		7b. HOUR <b>842</b>
3. SEX <b>Male</b>	4. RACE <b>CAUC</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11 12 25 58</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>58</b> YRS.	IF UNDER 1 YR. MONTHS DAYS <b>58</b>	IF UNDER 24 HRS. HOURS MIN. <b>58</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Iowa</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>11 25 83</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b>		7d. HOUR <b>842</b>	
10. CITY OR TOWN OF DEATH <b>ROCKVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SHADY GROVE REHABILITATION HOSP</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mechanical Engineer</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Viteo</b>		13a. STATE <b>MD</b>			
13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>ROCKVILLE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>4518 CHESTNUT LANE</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Samuel Cowan</b>			
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Edith Mae Schlicher</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>			
16b. SOCIAL SECURITY NO. <b>578-38-4511</b>		17. DECEASED'S ADDRESS <b>Anna V. Cowan (wife) 4518 Chestnut Lane Rockville, Md. 20853</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>ACUTE 9 YRS</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR <b>750 P.M. 11 25 1983</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>COLLAPSED AT HOME</b>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>4518 CHESTNUT LANE ROCKVILLE MONTGOMERY MD</b>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Francis C Mayo</b>		TITLE (SPECIFY) <b>Dept</b>		DATE SIGNED <b>11/26/83</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>FRANCIS C MAYO</b>		ADDRESS <b>2201 W. CONNOR AVE. BETHESDA MD</b>		MEDICAL EXAMINER	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/28/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring, Montgomery, Md.</b>		24. FUNERAL DIRECTOR NAME <b>Tyson Wheeler Funeral Home, Inc.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 30 1983</b>	
25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>		25c. ADDRESS <b>1331 Rockville Pike Rockville, Md. 20852</b>			

11

20% COTTON-FIBER

BP

DHMM - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

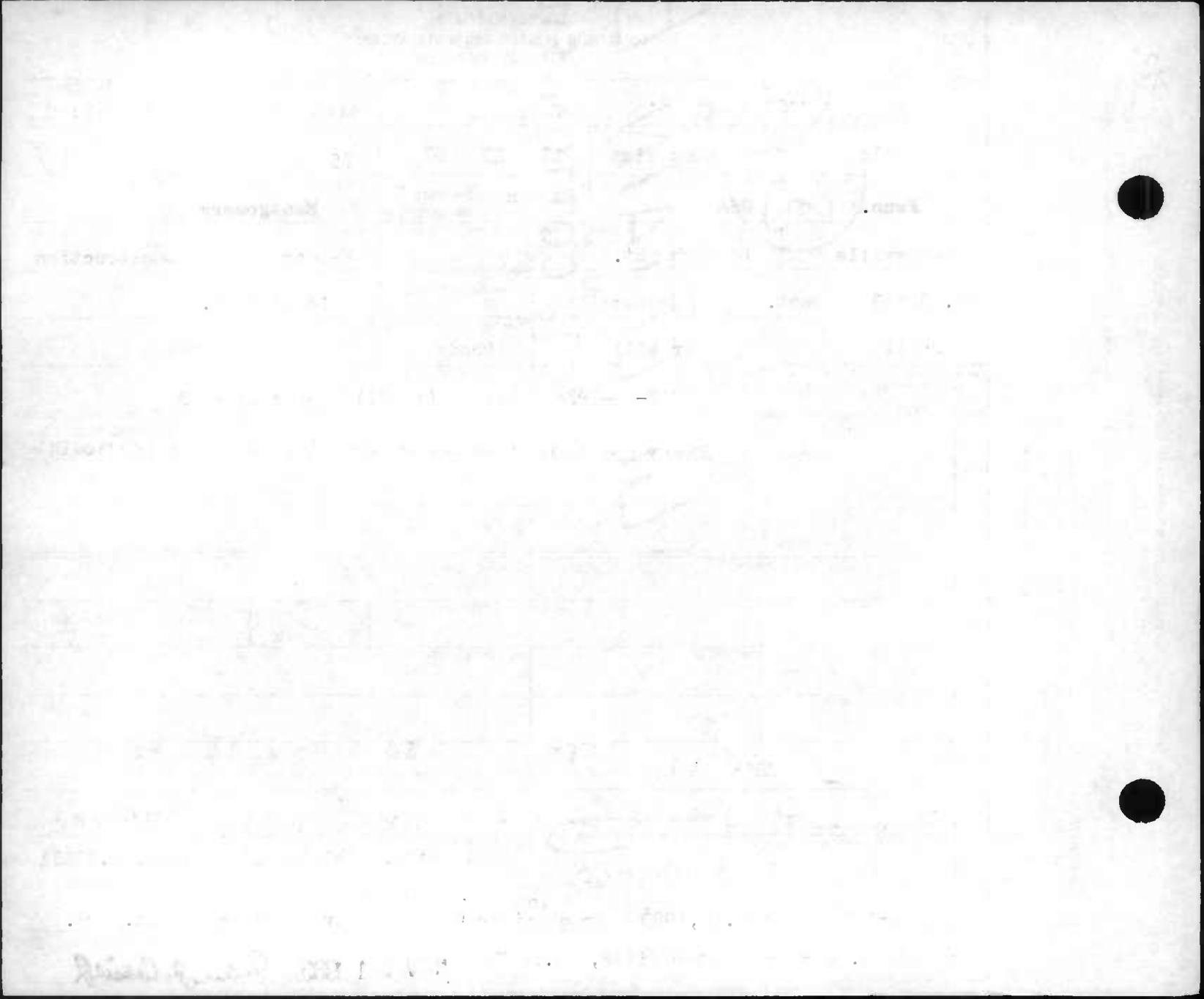
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <sup>FIRST</sup> AUSTIN <sup>MIDDLE</sup> P. <sup>LAST</sup> CRABILL					2a. DATE OF DEATH MONTH DAY YEAR Nov. 17, 1983	
3. SEX Male		4. RACE caucasian		5. DATE OF BIRTH MONTH DAY YEAR 12 23 07		
6. AGE (IN YEARS LAST BIRTHDAY) 75		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Brookeville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 14 High St.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Welder		
13a. STATE Md. 20833		13b. COUNTY Mont.		13c. CITY OR TOWN Brookeville		
14. FATHER'S NAME <sup>FIRST</sup> Philip <sup>MIDDLE</sup> <sup>LAST</sup> Crabill		15. MOTHER'S MAIDEN NAME <sup>FIRST</sup> Rhoda <sup>MIDDLE</sup> <sup>LAST</sup> Dodson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-09-7938		17. INFORMANT ADDRESS Flora Crabill Same as # 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SQUAMOUS CELL CARCINOMA OF LUNG</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MONTHS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>FEB</u> 19 <u>83</u> , to <u>NOV 17</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>NOV 12</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.						
22b. SIGNATURE <u>Eugene P. Flannery</u>		DEGREE MD		22c. DATE SIGNED 11/17/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE P. FLANNERY		22e. ADDRESS 18111 Prince Philip Drive Olney, Md. 20832				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 19, 1983		23c. NAME OF CEMETERY OR CREMATORY Salem Brookeville		
24. FUNERAL DIRECTOR NAME Francis H. Barber		ADDRESS Laytonsville, Md. 20879		25a. DATE REC'D. BY REGISTRAR NOV 21 1983		
		25b. REGISTRAR'S SIGNATURE <u>John J. Cairns</u>				

3 0 5 3 3



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 56 M 4/82  
(VRA 15, )



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 5 3 4

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST Gladys Armstrong Crabill		MONTH DAY YEAR 11/16/83	
3. SEX		4. RACE	
Female		white	
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
MONTH DAY YEAR 5 09 99		84	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	
New York		U.S.A.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
		Montgomery MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
Silver Spring		Holy Cross Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Homemaker			
13a. STREET ADDRESS		13b. INSIDE CITY LIMITS?	
4303 Garrett Park Road 20906		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
FIRST MIDDLE LAST George E. LaRue		FIRST MIDDLE LAST Carrie Fisher	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
No		214-74-7855	
17. INFORMANT		ADDRESS	
Daughter Marilyn Saunders		28733 Ridge Road Mt. Airy, Md. 21771	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) 4241 cardiovascular collapse			
DUE TO, OR AS A CONSEQUENCE OF (b) severe, calcific aortic stenosis and			
DUE TO, OR AS A CONSEQUENCE OF (c) chronic lung disease			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1a			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY	
		HOUR A.M. MONTH DAY YEAR P.M. 19	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22a. I certify that (I) (this hospital) attended the deceased from 11/14/83 to 11/16/83, that (I) (we) (we) saw the deceased alive on 11/15/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE		22c. DATE SIGNED	
Joseph M. Solinas M.D.		11/16/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
Joseph M. Solinas, M.D.		9801 Georgia Ave. Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Burial		Nov. 19, 1983	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Parklawn Cemetery		Rockville Montgomery Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR	
Francis J. Collins		NOV 25 1983	
500 University Blvd., W. Silver Spring, Md.		25b. REGISTRAR'S SIGNATURE	
		John J. Connel	

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 5 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 50M 4/82  
(VRA 15, 4)1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Virginia E. Crowder</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>16</b> YEAR <b>83</b>			2b. HOUR <b>1A</b> M			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH <b>November</b> DAY <b>6</b> YEAR <b>1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b>		IF UNDER 1 YEAR MONTHS <b>YRS.</b> DAYS <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Gaithersburg</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Wilson Health Care Center</b>		12a. USUAL OCCUPATION <b>Administrative Assistant</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Supreme Court</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Gaithersburg</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>401 Russell Avenue Apt 805</b>	
14. FATHER'S NAME FIRST <b>Charles</b> MIDDLE <b>Henry</b> LAST <b>Crowder</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Charlie</b> MIDDLE <b>G.</b> LAST <b>Wilson</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>579-38-7813</b>		17. INFORMANT (Sister) <b>Naomi Sue Allen</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CNS induced metabolic disturbance</b> <b>3310</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Alzheimer's Disease</b> (c) <b>Gyn.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs.</b>		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <b>May 24</b> 19 <b>79</b> , to <b>Nov 16</b> 19 <b>83</b> , that (1) (we) last saw the deceased alive on <b>Nov 14</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>James R. Moore Jr.</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-16-83</b>			
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James R. Moore Jr.</b>		22e. ADDRESS <b>207 Brookes Ave Gaithersburg Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov 18, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lakeview Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Blackstone</b> COUNTY <b>Virginia</b> STATE <b>Virginia</b>		23e. DATE REC'D. BY REGISTRAR <b>NOV 17 1983</b>	
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey</b> ADDRESS <b>Funeral Homes, P.A., Rockville, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 17 1983</b>							

MEDICAL CERTIFICATION



3 0 5 3 6


1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
JOSEPH				CROWN		Nov. 21, 1983					11:50am	
3 SEX		4. RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Male		White		Oct. 8, 1914		69		MONTHS		DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH						
Illinois		USA				Montgomery, MD						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Holy Cross Hospital				Owner (Ret.)			Laundry Machines			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
Maryland		Montgomery		Sil. Spg.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1000 Kersey Road 20902				
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME						
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST		
Herman				Crown		Tillie				Abrams		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT						
Yes				339-10-6858		Meyer Gelfand; 4200 Mass. Ave., NW, Wash. DC						
(IF YES, GIVE WAR OR DATES)												
WW II												

<b>18 CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <b>PART I. DEATH WAS CAUSED BY:</b>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>
<b>IMMEDIATE CAUSE (a)</b> <u>Respiratory Failure</u>		<u>5 min.</u>
<b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</b>	<b>DUE TO, OR AS A CONSEQUENCE OF</b> <b>(b)</b> <u>Adenosocarcinoma of Prostate</u>	<u>5 years</u>
	<b>DUE TO, OR AS A CONSEQUENCE OF</b> <b>(c)</b>	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/22</u> , 19 <u>80</u> , to <u>11/21</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>11/21</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-21-198	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDGAR H. LEVIN, M.D.				22e. ADDRESS 8630 Fenton Street; Silver Spring, Md. 209			

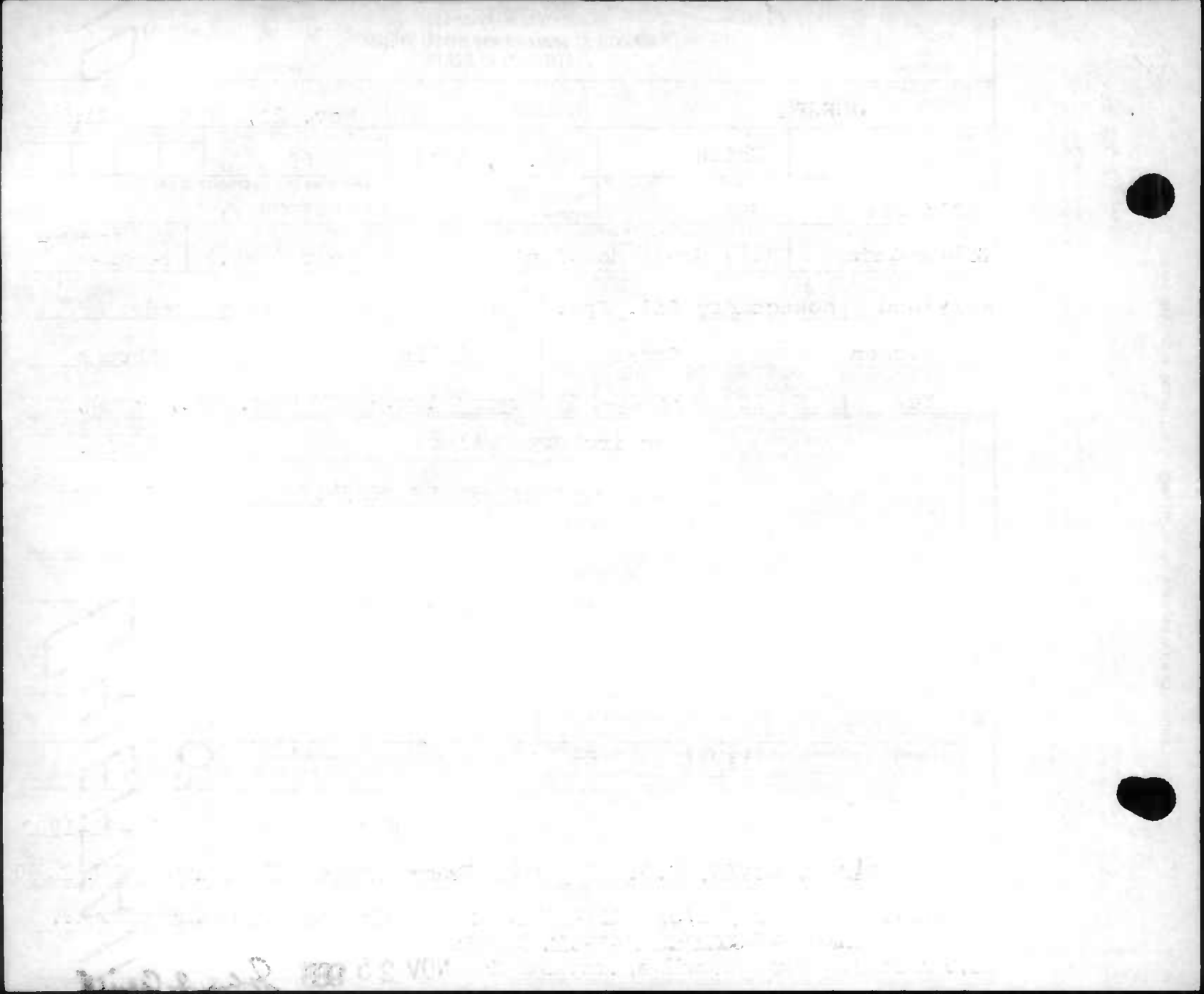
23a. BURIAL, CREMATION, REMOVAL SPECIFY <b>Burial</b>	23b. DATE <b>11/22/83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>KING DAVID MEMORIAL GDN.</b>	23d. LOCATION CITY OR TOWN <b>Falls Church</b> COUNTY <b>Fairfax</b> STATE <b>Va.</b>
24. FUNERAL DIRECTOR NAME <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 25 1983</b>	
ADDRESS <b>1170 Rockville Pike; Rockville, Maryland 20852</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the certificate should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP\_\_\_\_\_



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30537

1. FOR  
STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)FIRST MIDDLE LAST  
Edith E. CUSHING2a. DATE OF DEATH MONTH DAY YEAR  
NOV 6 19832b. HOUR  
1:09 PM

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH

MONTH DAY YEAR  
Dec. 16, 1914

6. AGE (IN YEARS LAST BIRTHDAY)

68 YRS

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

7a. BIRTHPLACE

(STATE OR FOREIGN COUNTRY)  
Mass.

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Montgomery MD.

10. CITY OR TOWN OF DEATH

Bethesda

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
SUBURBAN HOSPITAL

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)  
Housewife

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE  
Arkansas13b. COUNTY  
Grant13c. CITY OR TOWN  
Sheridan13d. INSIDE CITY LIMITS?  
YES ☐ NO ☒13e. STREET ADDRESS  
Box 187

72150

14. FATHER'S NAME

FIRST MIDDLE LAST  
George Wellner

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST  
Alma Spinney16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO OR UNKNOWN)  
No16b. SOCIAL SECURITY NO.  
031-21-7061

17. INFORMANT

George C. Cushing,

ADDRESS

11004 Haney Terr.  
Damascus, Md. 2087218. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

5188

IMMEDIATE CAUSE (a)

Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Hypoxemia, Respiratory failure

DUE TO, OR AS A CONSEQUENCE OF

(c)

severe chronic lung disease

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

probable cancer lung

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☒ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 10:30 - 1983 to 11:6 1983, that (I) (we) last saw the deceased alive on 11-6-1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Hadi Bahar

DEGREE

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED

11-6-83

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

HADI BAHAR

22e. ADDRESS

5218 Wisconsin Ave. - Beth

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Cremation

23b. DATE

Nov. 7, 1983

23c. NAME OF CEMETERY OR CREMATORY

Westview

23d. LOCATION

Baltimore, Maryland

STATE

24. FUNERAL DIRECTOR

Orrin L. Molesworth, P.A., Damascus, Md.

25a. DATE REC'D. BY REGISTRAR

NOV 8 1983

25b. REGISTRAR'S SIGNATURE

James C. Grier

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D. C. 20250

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UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D. C. 20250

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Possession retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

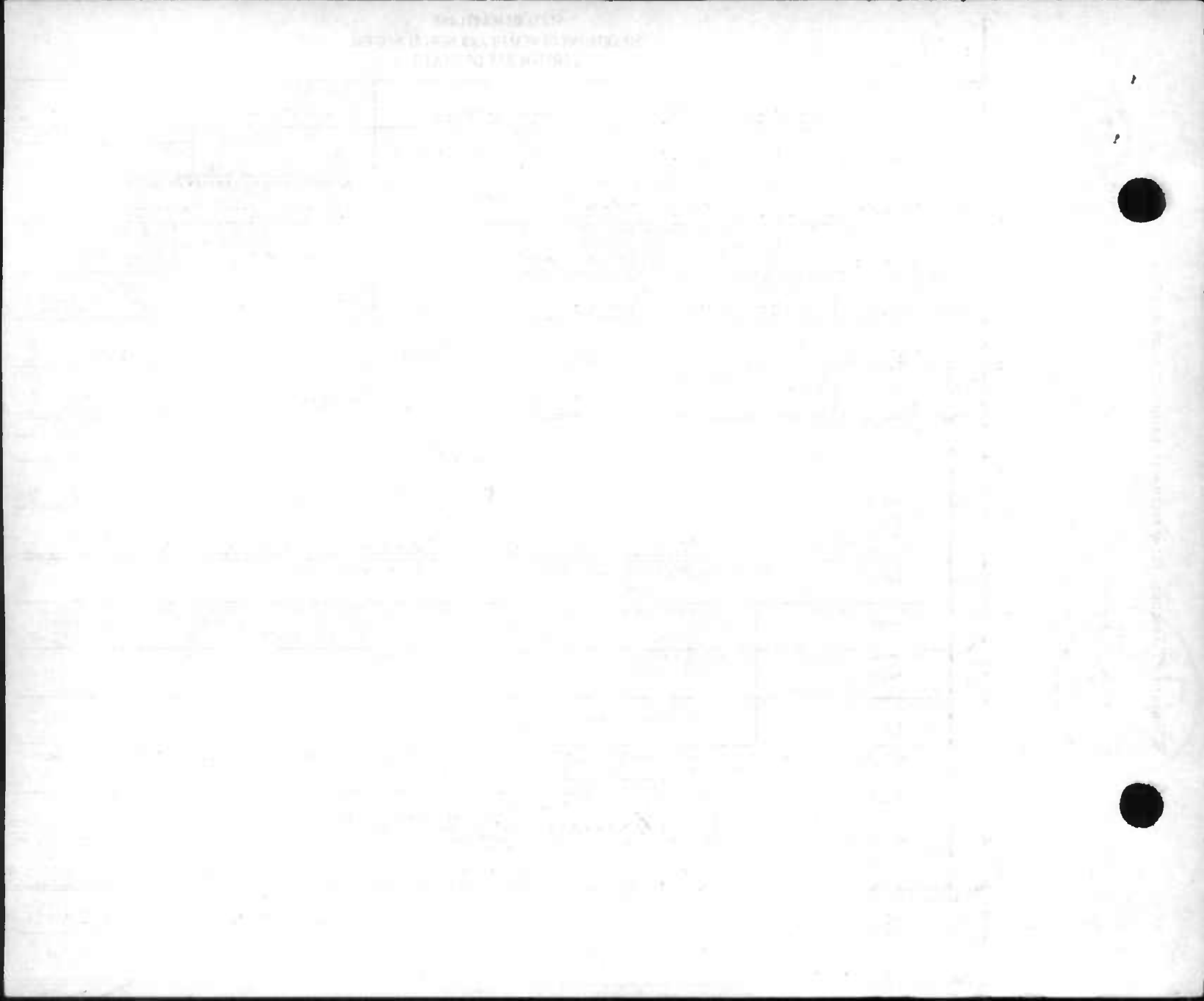
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30538

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Beatrice F. Dangerfield</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 2, 1983</b>		2b. HOUR <b>6:00P M</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 23, 1902</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b>		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C. United States</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD</b>		10. CITY OR TOWN OF DEATH <b>Potomac</b>		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>9318 Kendale Road</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Potomac</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Michael Flaherty</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Lacey</b>		16. SOCIAL SECURITY NO. <b>218 56 5135</b>		
17. INFORMANT <b>Husband</b>		18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrhythmia</b> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Atherosclerotic Cardiovascular Disease</b> Unk.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Unk.</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Unk.</b>						
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>May 17, 1983</b> to <b>Nov 4, 1983</b> , that (I) (we) last saw the deceased alive on <b>Oct 10, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.						
22b. SIGNATURE <b>Augustus D. Aquino</b> DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>Nov. 4, 1983</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Augustus Aquino, M.D.</b>				22e. ADDRESS <b>20814 10401 Old Georgetown Rd. Bethesda, Md</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 5, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Maryland</b>		24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland</b>				
25a. DATE REC'D. BY REGISTRAR <b>NOV 7 1983</b>				25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>		

BP.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

Cleared by Coroner

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be held and a report filed.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30539

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>William Henry Daniels</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-03-83</b>		2b. HOUR MIN. <b>Approx 6 A.M.</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>02-11-11</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>72</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, DC</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.		
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>305 Highview Ave</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF LIFE) <b>Supt. Rds. &amp; Grounds</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>US Govt.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Silver Spring</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>305 Highview Ave., 20901</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry J. Daniels</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Flossie Barney</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>N/A</b>		16b. SOCIAL SECURITY NO. <b>579-03-5074</b>		17. INFORMANT ADDRESS <b>Margaret Carruth-daughter-(same as 13e)</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Artery Disease</b> 4149 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Diabetes mellitus, Hypertension, Renal Insufficiency</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I, the hospital) attended the deceased from <b>4-23</b> 19 <b>79</b> to <b>11-3</b> 19 <b>83</b> that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>10-25</b> 19 <b>83</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death.						
22b. SIGNATURE <b>John Koje, Jr. MD</b>		DEGREE		22c. DATE SIGNED <b>1-3-83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John Koje, Jr. MD</b>		22e. ADDRESS <b>344 Univ. Blvd. W. Silver Spring, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-7-1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood Pr. Georges Md.</b>		23e. DATE REC'D. BY REGISTRAR <b>NOV 4 1983</b>				
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi Funeral Home</b>		ADDRESS <b>11800 N.H. Ave., Silver Spring, Md.</b>		25. REGISTRAR'S SIGNATURE <b>[Signature]</b>		



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. RETAIN PAGE 4. SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3, WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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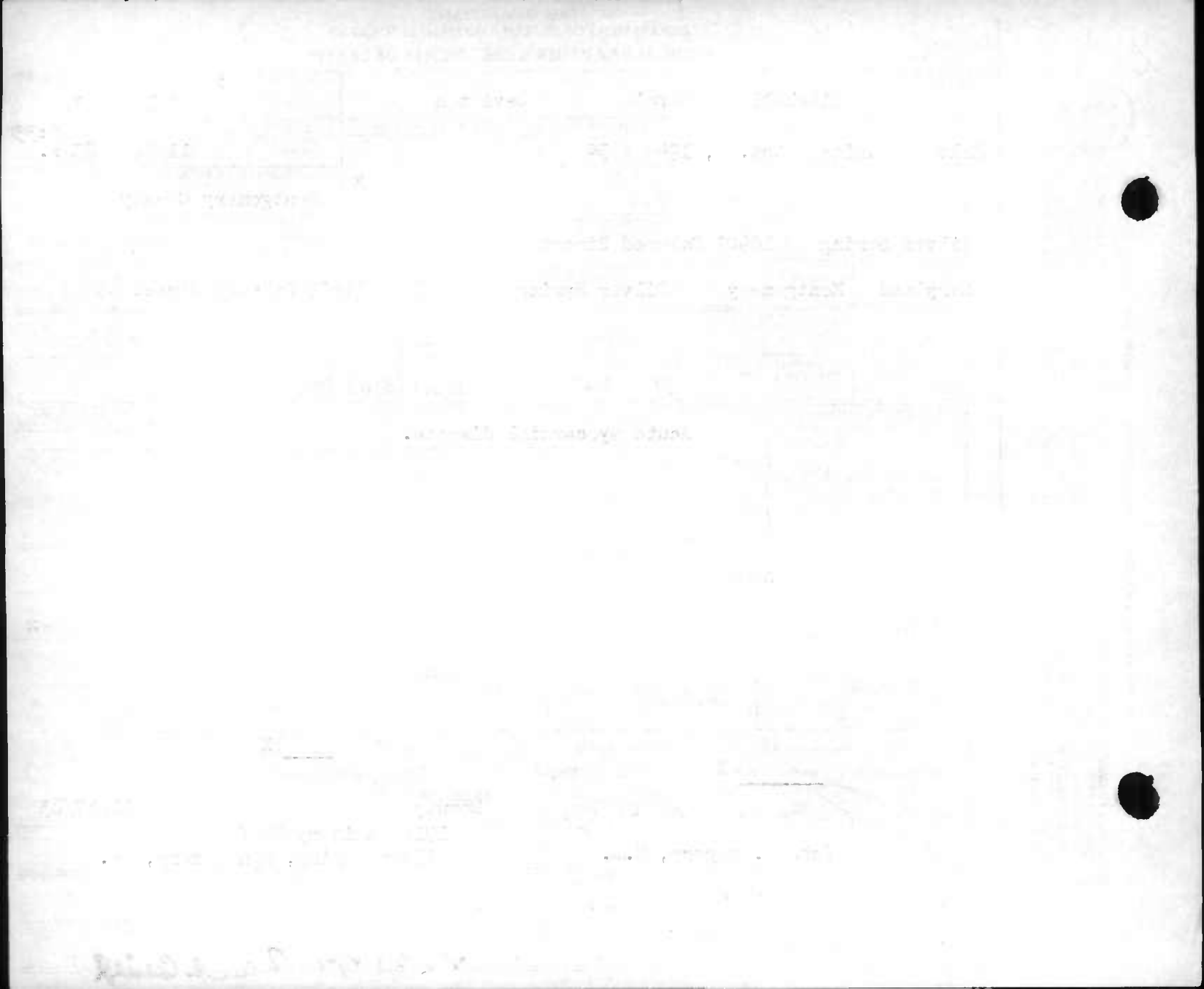
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(VR A15 ME (5))  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30540

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE ESTIMATED		2d. DATE PRONOUNCED DEAD	
Mitchell G. Davidson		11/16 19 83		11/16 19 83 P.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.
Male	White	Oct. 9, 1944	39 YRS.	MONTHS	DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED	
New Jersey		U. S. A.		NEVER MARRIED	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Silver Spring		10902 Oakwood Street		C.P.A.	
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS	
Maryland		Montgomery		Silver Spring	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.	
Max		Gertrude		215-44-4113	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Max Davidson (Same as # 13)		PART I DEATH WAS CAUSED BY: Acute myocardial disease.			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
None		None		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
		P.M. 19		None	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on					
Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion					
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
John S. Rogers, M.D.		Deputy		11/17/83	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		MEDICAL EXAMINER	
		1919 Seminary Road		Silver Spring, Montgomery, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		11/18/1983		Mount Lebanon	
23d. LOCATION (CITY OR TOWN)		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
Hyattsville, P. G. Md.		NOV 21 1983		J. S. Rogers	
24. FUNERAL DIRECTOR					
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME					
232 CARROLL STREET, N. W., WASHINGTON, D. C.					

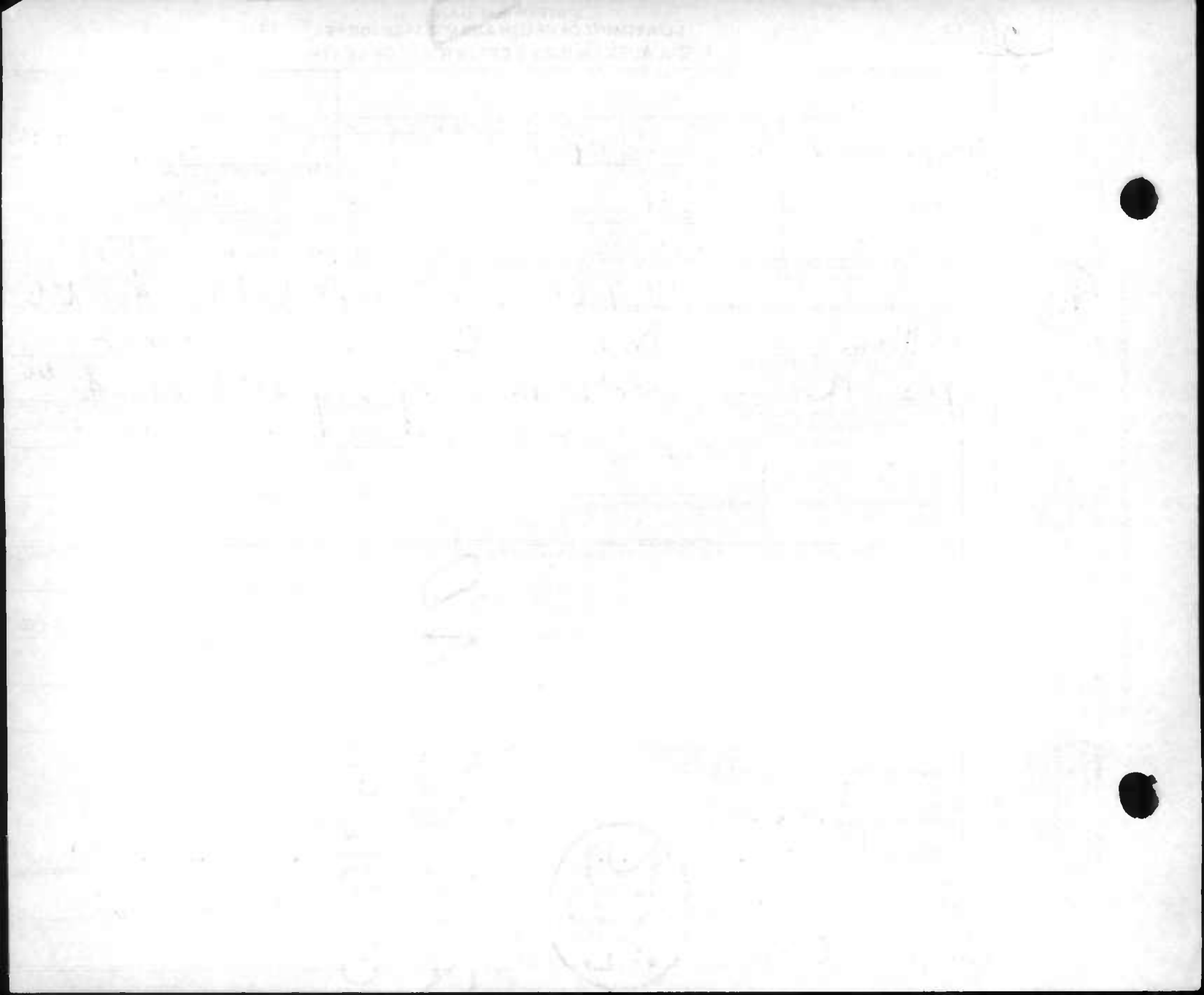


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PV-1000, "PAGE 5 FOR YOUR FILES." TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE USED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			3. DATE OF BIRTH			4. AGE (IN YEARS)			5. IF UNDER 1 YR.			6. IF UNDER 24 HRS.			7. DATE PRONOUNCED DEAD			8. BALTIMORE CITY OR COUNTY OF DEATH								
John David Day			11/20/83			11 27 32			50 YRS.			MONTHS DAYS HOURS MIN.			MONTHS DAYS HOURS MIN.			11/20/83			Montgomery County								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY			13. CITY OR TOWN			13a. INSIDE CITY LIMITS?			13b. STREET ADDRESS			13c. STREET ADDRESS								
Takoma Park			Washington Adventist Hospital			Repairman			T.V.			Wash. D.C.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			643 Nicholson Ave. N.E.			643 Nicholson Ave. N.E.								
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT			17a. ADDRESS			17b. ADDRESS			17c. ADDRESS								
William			Catherine			Yes <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES)			229-48-3195			Cathy Day			643 Nicholson Ave. N.E.			643 Nicholson Ave. N.E.			643 Nicholson Ave. N.E.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART I DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease																													
DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																													
(b)																													
DUE TO, OR AS A CONSEQUENCE OF																													
(c)																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																													
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?											
																		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
						P.M. 19																							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION CITY OR TOWN COUNTY STATE																	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																													
ACTUAL SIGNATURE										TITLE (SPECIFY)										DATE SIGNED									
Ann M. Dixon, M.D.										Assistant										11/21/83									
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS										111 Penn St., Balto., Md. 21201									
23a. BURIAL, CREMATION, REMOVAL						23b. DATE						23c. NAME OF CEMETERY OR CREMATORY						23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial						11-25-83						Catholics Church Cem.						Chatham Va.											
24. FUNERAL DIRECTOR NAME						24b. ADDRESS						25a. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE											
Carlton C. Douglass						1012 Penn Ave.						NOV 22 1983						John S. Smith											



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

30542

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
FIRST MIDDLE LAST William R. De Cesare			MONTH DAY YEAR 11.22.1983			11:30P		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	7d. HOUR	
M	CAUC	MONTH DAY YEAR 11 33	50 YRS.	MONTHS DAYS	HOURS MIN	MONTH DAY YEAR 11.22.1983	11:30P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH		
New Jersey			United States			Montgomery County, MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK)		
Bethesda			Suburban Hospital			Physician		
12b. KIND OF BUSINESS OR INDUSTRY			12c. STREET ADDRESS			12d. ADDRESS		
U.S. Govt			20814 National Inst.			5216 Carlton		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
MD			MONTGOMERY			BETHESDA		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		
FIRST MIDDLE LAST James C. DeCesare			FIRST MIDDLE LAST Sally Juaneta Ray			16b. SOCIAL SECURITY NO.		
16c. YES			16d. NO			16e. ADDRESS		
16f. YES			16g. NO			16h. ADDRESS		
16i. YES			16j. NO			16k. ADDRESS		
16l. YES			16m. NO			16n. ADDRESS		
16o. YES			16p. NO			16q. ADDRESS		
16r. YES			16s. NO			16t. ADDRESS		
16u. YES			16v. NO			16w. ADDRESS		
16x. YES			16y. NO			16z. ADDRESS		
16aa. YES			16ab. NO			16ac. ADDRESS		
16ad. YES			16ae. NO			16af. ADDRESS		
16ag. YES			16ah. NO			16ai. ADDRESS		
16aj. YES			16ak. NO			16al. ADDRESS		
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16bt. YES			16bu. NO			16bv. ADDRESS		
16bw. YES			16bx. NO			16by. ADDRESS		
16bz. YES			16ca. NO			16cb. ADDRESS		
16cc. YES			16cd. NO			16ce. ADDRESS		
16cf. YES			16cg. NO			16ch. ADDRESS		
16ci. YES			16cj. NO			16ck. ADDRESS		
16cl. YES			16cm. NO			16cn. ADDRESS		
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16kl. YES			16kl. NO			16km. ADDRESS		
16km. YES			16km. NO			16kn. ADDRESS		
16kn. YES			16kn. NO			16ko. ADDRESS		

AT 22. 1. 1954

1954. 1. 22. 1. 1954



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR				REG. NO.		30543			
1. DECEASED NAME (TYPE OR PRINT) DONALD JAMES DECKER					2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 25 1983		2b. HOUR 6:18 <sup>a</sup> M		
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR SEPTEMBER 3 1908		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY U.S.M.C.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN CHEVY CHASE					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 6012 BROOKSIDE DRIVE 20815		
14. FATHER'S NAME FIRST MIDDLE LAST JAMES DEWITT DECKER					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNIE RICHARDSON				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1932-1964		16c. 576-38-0389		17. INFORMANT ADDRESS MARION G. DECKER, 6012 BROOKSIDE DRIVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) <u>STROKE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>OCTOBER 18</u> , 19 <u>83</u> , to <u>NOVEMBER 25</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>NOVEMBER 25</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>R. P. Sen</i> 22b. PHYSICIAN'S NAME (TYPE OR PRINT) R. P. SEN, LT, MC, USNR				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 25 Nov 83			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE NOV 30, 1983		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Va.	
24. FUNERAL DIRECTOR NAME DeVol Funeral Home				ADDRESS Washington, D.C.		25. DATE REC'D BY REGISTRAR DEC 01 1983		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



RECEIVED

John W. ...

file

100-2-717

OR as per Dr. Rogers  
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 5 4 4

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Pamela Dawn Decker			2a. DATE OF DEATH MONTH DAY YEAR 11-----9-----83		2b. HOUR 1:12p <sub>M</sub>	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR October 12, 1951		
6. AGE (IN YEARS LAST BIRTHDAY) 32		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) school teacher		12b. KIND OF BUSINESS OR INDUSTRY County Schools		13. STREET ADDRESS (20903) 1432 Hampshire West Court		
13a. STATE MD		13b. CITY OR TOWN silver spring		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Harry Decker		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Esther Walterick		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		
16b. SOCIAL SECURITY NO. 177-42-3798		17. INFORMANT Mrs J. Robert Meyers		ADDRESS 8180 Lincoln Way St. Thomas, PA 17252		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) RESPIRATORY ARREST 2°  
DUE TO, OR AS A CONSEQUENCE OF  
(b) BILATERAL PNEUMONIA  
DUE TO, OR AS A CONSEQUENCE OF  
(c) 5120

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION NA		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NA		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. CERTIFY that (I) (this hospital) attended the deceased from <u>11-3-83</u> to <u>11-8-83</u> , that (I) (we) last saw the deceased alive on <u>11-3-83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE S. Wenzel M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-8-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ISAAC WEISZEL		22e. ADDRESS 10215 FERNWOOD RD		22f. CITY OR TOWN BALTIMORE			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 13, 1983		23c. NAME OF CEMETERY OR CREMATORY Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Chambersburg Pennsylvania	
24. FUNERAL DIRECTOR 397 PHILA AVE		ADDRESS CHAMBERSBURG PA 17001		25. DATE REC'D. BY REGISTRAR NOV 15 1983		25b. REGISTRAR'S SIGNATURE John J. Connel	

(M)

*[Faint, illegible handwritten text]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>CHARLES WESLEY DEMENT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 15 1983</b>		2b. HOUR <b>11:45<sup>P</sup>M</b>		
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JANUARY 25 1941</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <b>42</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WEST VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. NAVY</b>	
13a. STATE <b>WEST VIRGINIA</b>		13b. COUNTY <b>KANAWHA</b>		13c. CITY OR TOWN <b>CHARLESTON</b>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES	
14. FATHER'S NAME FIRST MIDDLE LAST <b>RALPH EMERSON DEMENT</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ONA PEARL MULLINS</b>		13e. STREET ADDRESS <b>5369 Big Tyler Road</b>		(25313)	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1959-1977</b>		17. INFORMANT (wife) <b>MARTHA B. DEMENT,</b>		ADDRESS <b>5369 Big Tyler Road, Charleston, W. VA.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

2050 IMMEDIATE CAUSE (a) **MULTIPLE MYELOMA**

DOE TO, OR AS A CONSEQUENCE OF

(b) **ACUTE MYELOGINOUS LEUKEMIA**

DOE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (he) (this hospital) attended the deceased from <b>AUGUST 31</b> , 19 <b>83</b> , to <b>NOVEMBER 15</b> , 19 <b>83</b> , that (we) (we) last saw the deceased alive on <b>NOVEMBER 15</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>R. L. Sollock</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>17 Nov 83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. L. SOLLOCK, LCDR, MC, USN</b>		22e. ADDRESS <b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 19, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cunningham Memorial Park,</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>St. Albans, W. Va.</b>	
24. FUNERAL DIRECTOR NAME <b>Capitol Funeral Service, Falls Church, VA</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 21 1983</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Connelley</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified of course.

STATE OF CALIFORNIA  
COUNTY OF LOS ANGELES  
OFFICE OF THE COUNTY CLERK

[Faint, illegible text covering the majority of the page, likely a document or form.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the law, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Rajeshwar V. Deshmukh		11 29 83		0030 M	
3. SEX Male	4. RACE Indian	5. DATE OF BIRTH September 1, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 76	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) India	7b. CITIZEN OF WHAT COUNTRY? India	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Industrialist		12b. KIND OF BUSINESS OR INDUSTRY Textile
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME Vyanakatesh		15. MOTHER'S MAIDEN NAME Janakibai		16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Zip: 20817 7204 Grubby Thicket Way	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT (Wife) Tarabai Deshmukh, Way, Bethesda, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastric Carcinoma with diffuse</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>intraabdominal metastases</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1519</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Previous Gastric Resection</u>					
19a. DATE OF OPERATION 10/14	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Recurrent Carcinoma with Obstruction		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <del>XXXXXX</del> attended the deceased from <u>October 83</u> to <u>Nov. 29 83</u> , that (I) (we) last saw the deceased alive on <u>Nov. 18 83</u> , and that in (my) <del>XXX</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>XX</del> (we) <del>XXXX</del> view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/29/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. S. Sander		22e. ADDRESS 6490 Candover Rd Candover MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE Nov. 29, 1983	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Bladensburg Maryland	
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A., 7557 Wisconsin Avenue, Bethesda, Maryland		25. DATE REC'D. BY REGISTRAR 25. REGISTRAR'S SIGNATURE DEC 2 1983 <u>[Signature]</u>			

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

3 0 5 4 7

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Elaine M. Devett</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-05-83</b>		2b. HOUR <b>7:45</b> AM			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>February 25, 1931</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>52</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Letter Carrier</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Postal Service</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>5806 Phoenix Drive</b>			13f. Zip: <b>20817</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Farran</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Adele Plummer</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>175-24-0452</b>		17. INFORMANT ADDRESS <b>Charles J. Devett, Husband, Same as #13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocardial infarction - 20 years</b> 4960 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <b>longstanding chronic obstructive pulmonary disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>arteriosclerosis</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>none</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>10/11/82</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>—</b>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>—</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>—</b>				
22a. I certify that (I) (this hospital) attended the deceased from <b>10/11/82</b> 19 <b>82</b> to <b>11/5</b> 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>11/4</b> 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Robert A. Pumphrey</b>				DEGREE <b>Attending Physician</b>		22c. DATE SIGNED <b>11/5/83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EMOT R GOUDSTEN</b>				22e. ADDRESS <b>9410 OLD GEORGETOWN</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>November 6, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria, Virginia</b>		
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 7 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20% CO. 10M 11

CHILLMAN

Whitehead Sanatorium Hospital

Sanatorium (Ct.)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at page.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30548

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HELEN C. DILLMAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 30 1983</b>		2b. HOUR <b>4:20 P.M.</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 8 1901</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Indiana</b>		8. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Indiana</b>		9b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.		
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3700 King William Drive</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Fur Business</b>		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Olney</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry C. Coats</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Cordelia (Unknown)</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>578-07-6006</b>		17. INFORMANT ADDRESS <b>Helen I. Person Niece Same as 13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Tongue</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 months</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>March 1, 1983</b> to <b>Nov 30, 1983</b> , that (I) (we) last saw the deceased alive on <b>Nov 15, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Blaine H. Eig</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>Dec 1, 1983</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BLAINE H. EIG</b>		22e. ADDRESS <b>9801 Georgetown Road Spring Md 20902</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec. 3, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Strang's Cemetery</b>		
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 6 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>South Mountain Franklin Pa.</b>						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Every death must be reported to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CHARLES ANTHONY DIAS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>MAY 25, 1983</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		2b. HOUR <b>3:30AM</b>	
5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 25, 1983</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>7 1 0</b>		IF UNDER 1 YEAR IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONT.</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON ADVENTIST HOSPITAL</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>n/a</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>n/a</b>		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <b>MD MONT. TAKOMAPARK</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Andrew Clement Dias</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sandra Marie Taylor</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>n/a</b>		16b. SOCIAL SECURITY NO. <b>n/a</b>		17. INFORMANT ADDRESS <b>MOTHER AND FATHER</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>7650 Extreme Prematurity</b> IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					
19a. DATE OF OPERATION <b>n/a</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>n/a</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>n/a</b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>n/a 19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>n/a</b>		21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> <b>n/a</b>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>n/a</b>	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>n/a</b>		22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>John O. Keller</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>11-12-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN KELLEHER</b>		22e. ADDRESS <b>7600 Carroll Ave Takoma Park, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Nov 21 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington Adventist</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Takoma Park Mnt. MD</b>		25a. DATE RECEIVED BY REGISTRAR <b>Nov 21 1983</b>			
24. FUNERAL DIRECTOR NAME <b>Herbert Z. Shiroma</b>		25b. ADDRESS <b>7600 Carroll Ave. TP. MD</b>			





BP \_\_\_\_\_  
DHMH - 16 50M 4/82  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR		TWIN A		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		30550		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)				DAVID MICHAEL DIAS		2a. DATE OF DEATH MONTH DAY YEAR			
3. SEX				4. RACE		5. DATE OF BIRTH			
MALE				WHITE		MAY 25, 1983			
6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
MARYLAND				U.S.		9. BALTIMORE CITY OR COUNTY OF DEATH			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
TAKOMA PARK				WASHINGTON ADVENTIST HOSPITAL		N/A			
13a. STATE				13b. CITY OR TOWN		13c. STREET ADDRESS			
MD				Takoma Park		7519 Maple Ave. 20912			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
Andrew Clement Dias				Sandra Marie Taylor		NO			
16b. SOCIAL SECURITY NO.				17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7650 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)			
N/A				MOTHER AND FATHER		Extreme Prematurity			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
				P.M. n/a 19		n/a			
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
n/a				n/a		n/a			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
				John J. Kelleher				11-12-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			
JOHN KELLEHER:				7600 Carroll Ave. Takoma Park MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Cremation						Washington Adventist		Takoma Park Mont. MD	
24. FUNERAL DIRECTOR				25a. DATE RECEIVED BY REGISTRAR		25b. DATE RECEIVED BY REGISTRAR		25c. DATE RECEIVED BY REGISTRAR	
Herbert Z. Shiroma 7600 Carroll Ave. T.P. MD									

TO : [illegible]  
FROM : [illegible]  
SUBJECT : [illegible]  
[The following text is extremely faint and largely illegible, appearing to be a memorandum or report with several paragraphs of text.]





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Virginia Dilliplane</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>11 22 83</i>			2b. HOUR <i>5:55A.M.</i>				
3. SEX <i>FEMALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>DEC 21 1921</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>61</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>OHIO</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY CO</i> MD.				
10. CITY OR TOWN OF DEATH <i>TAKOMA PARK</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>21 DARWIN AVE.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSE WIFE</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <i>MD</i>			13b. COUNTY <i>MONTGOMERY</i>		13c. CITY OR TOWN <i>TAKOMA PARK</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>FRANK NIMI MILINSKY</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ANNA NIMI UNKNOWN</i>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>270-22-2203</i>	
17. INFORMANT ADDRESS <i>21 DARWIN AVE, TAKOMA PARK, MD.</i>										

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) *Pancreatic Carcinoma*

*1579*  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 16, 19 83</i> , to <i>Nov 22, 19 83</i> , that (I) (we) lost saw the deceased alive on <i>Nov 21, 19 83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Bernard A. Heckman, M.D.</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11/22/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>BERNARD A. HECKMAN, M.D.</i>				22e. ADDRESS <i>8830 CAMERON ST, SILVER SPRING, MD.</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>Nov. 23, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Metropolitan Crematory</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Alexandria Virginia</i>	
24. FUNERAL DIRECTOR NAME <i>Francis J. Collins</i>				25a. DATE REC'D. BY REGISTRAR <i>NOV 25 1983</i>		25b. REGISTRAR'S SIGNATURE <i>San J. Gaud</i>	
500 University Blvd., W. Silver Spring, Md.							

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Burial or cremation may not be made until after the death certificate has been filed with the health department.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP \_\_\_\_\_

DHMH-16-25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
REG. NO. 30552									
1. DECEASED NAME (TYPE OR PRINT) <b>John NMI Dimick</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>November 25, 1983</b>		2b. HOUR <b>9 P M</b>		
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Feb. 7, 1899</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>84</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kentucky</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10 CITY OR TOWN OF DEATH <b>Chevy Chase</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8101 Connecticut Avenue</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Archeologist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>University</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Md. 20815</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Chevy Chase</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>8101 Connecticut Avenue</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>George H. Dimick</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Hopkins</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>WW II 398-11-0811</b>		17 INFORMANT ADDRESS <b>John M. Lynham, Sr., 888-16th St., NW, Wash., D.C.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ADENOCARCINOMA RIGHT LUNG</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 HRS</b> <b>3 MONTHS</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <b>Sept 1983</b> , to <b>NOV 25 1983</b> , that (I) (we) last saw the deceased alive on <b>NOV 25 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Harold M. Silver</b> M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>NOV 25 1983</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Harold M. Silver</b>					22e. ADDRESS <b>1601 - 18th St., NW, Washington, D.C. 20009</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>11/29/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Maryland</b>			
24 FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons, Inc.</b>					25a. DATE REC'D. BY REGISTRAR <b>DEC 5 1983</b>				
25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>					25c. ADDRESS <b>5130 Wisconsin Ave., NW, Washington, D.C. 20016</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, report should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30553

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>DIXON, HENRY L</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11/14/83</b>		2b. HOUR <b>4:12 PM</b>
3. SEX <b>MALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10/19/13</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS	IF UNDER 1 YEAR MONTH DAY MONTHLY IF UNDER 24 HRS MONTHLY
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>U.S.A.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. CITY OR TOWN <b>SILVER SPRING</b>		13b. STREET ADDRESS <b>9717 ADMIRALTY DR</b>	
13a. STATE <b>MARYLAND</b>	13b. COUNTY <b>MONTGOMERY</b>	14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry Lee Dixon</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rachel Acwith</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Not Stated</b>		16b. SOCIAL SECURITY NO. <b>000121398</b>		17. INFORMANT ADDRESS <b>Mayme E. Dixon, Wife 9717 Admiralty Dr., SS, Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CORONARY ARTERY DISEASE</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>NO</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION <b>11/14/83</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>4148</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <b>11/14/83</b> to <b>11/14/83</b> , that (I) (we) lost sight of the deceased on <b>11/14/83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did not view the body after death.			
22b. SIGNATURE <b>Daniel I Woronow MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/14/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DANIEL I WORONOW</b>		22e. ADDRESS <b>106 IRVING ST #404 (NW) WASHINGTON, DC</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>18 Nov 83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial Cem.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, P. G. Co., Maryland</b>		24. FUNERAL DIRECTOR <b>W. Ernest Jarvis Co., Inc. 1432 You St., NW Washington, D. C.</b>			
25. DATE RECD. BY REGISTRAR <b>NOV 23 1983</b>		26. REGISTRAR'S SIGNATURE <b>John J. Gresh</b>			

BP

W. Ernest Jarvis Co., Inc. Washington, D. C.  
1132 You St., NW  
18 Nov 83 Date in Memorial Cem. Suitland, P. O. Co., Maryland

Not Stated

Henry Lee Dixon

Rachel Acworth

Mayne E. Dixon, wife of Henry Lee Dixon, Jr., 22, No

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Lawrence E. Dixon Sr.</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>11 26 83</b>		2b. HOUR <b>12 15 A.M.</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 26, 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>74</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington S.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>C. U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD.</b>					
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Electrician.</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>13a. STATE Md.</b>						13b. CITY <b>Montg.</b>		13c. ZIP CODE <b>Kensington.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Dixon.</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rose Norline.</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes.</b>						16b. SOCIAL SECURITY NO. <b>W. W. 2 Army. 214-03-</b>		17. INFORMANT <b>11015 Cone Ln. Wheaton.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dissected Craniomastoid</b> <b>1850</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary of Pericard</b> (c) <b>Due to, or as a consequence of</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b> <b>3 yrs</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Diabetic Mellitus, Arteriosclerosis, COPD.</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>July 12, 19 80</b> , to <b>Nov 24, 19 83</b> , that (I) (we) lost saw the deceased alive on <b>Nov 24, 19 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Eugene P. Libe</b>				DEGREE <b>MD</b>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EUGENE P. LIBE MD</b>				22e. ADDRESS <b>10400 Connecticut Ave Kensington Md. 20891</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 29. 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rockville, Montg. Md.</b>					
24. FUNERAL DIRECTOR <b>Arthur Walters</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 30 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>					
26. ADDRESS <b>Takoma Funeral Home Inc. 254 Carroll St. N. W. D. C.</b>											

BP



Jan. 26, 1969

Washington D. C. U. S. A.

Hospital. Retired Electrician.

3114 43-wood Rd.

+ Kensington.

Moner.

Ms.

London.

Jose

Dixon.

George

London.

W. W. S. Army. 214-03-5115

Yes.

London. 214-03-5115

London. 214-03-5115

London. 214-03-5115

London. 214-03-5115



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30555

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ERNEST Robert DLESK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-18-83</b>		2b. HOUR <b>6:40 A.M.</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JAN 20 1928</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Silver Spring Mont Co. Md.</b>			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASH. Adventist Hosp</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Programmer</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>		13b. CITY OR TOWN <b>New Carrolltown</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>8500 Oliver St (210)</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>OTTO (NA) DLESK</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sylvia Ebbly DLESK</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1945-51 286-34-788</b>		17. INFORMANT <b>Hermine Dlesk (same as #13)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>1539</b> IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cancer - metastatic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1h</b> <b>1h</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 8</b> , 19 <b>83</b> , to <b>Nov</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>11/17</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>MARTIN D. WELTZ</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>11/8/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARTIN D. WELTZ</b>				22e. ADDRESS <b>7676 New Hampshire Ave Langley Park</b>					
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>21 Nov 83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Saunderstown MD.</b>			
24. FUNERAL DIRECTOR <b>Harold Latham F.H.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 22 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

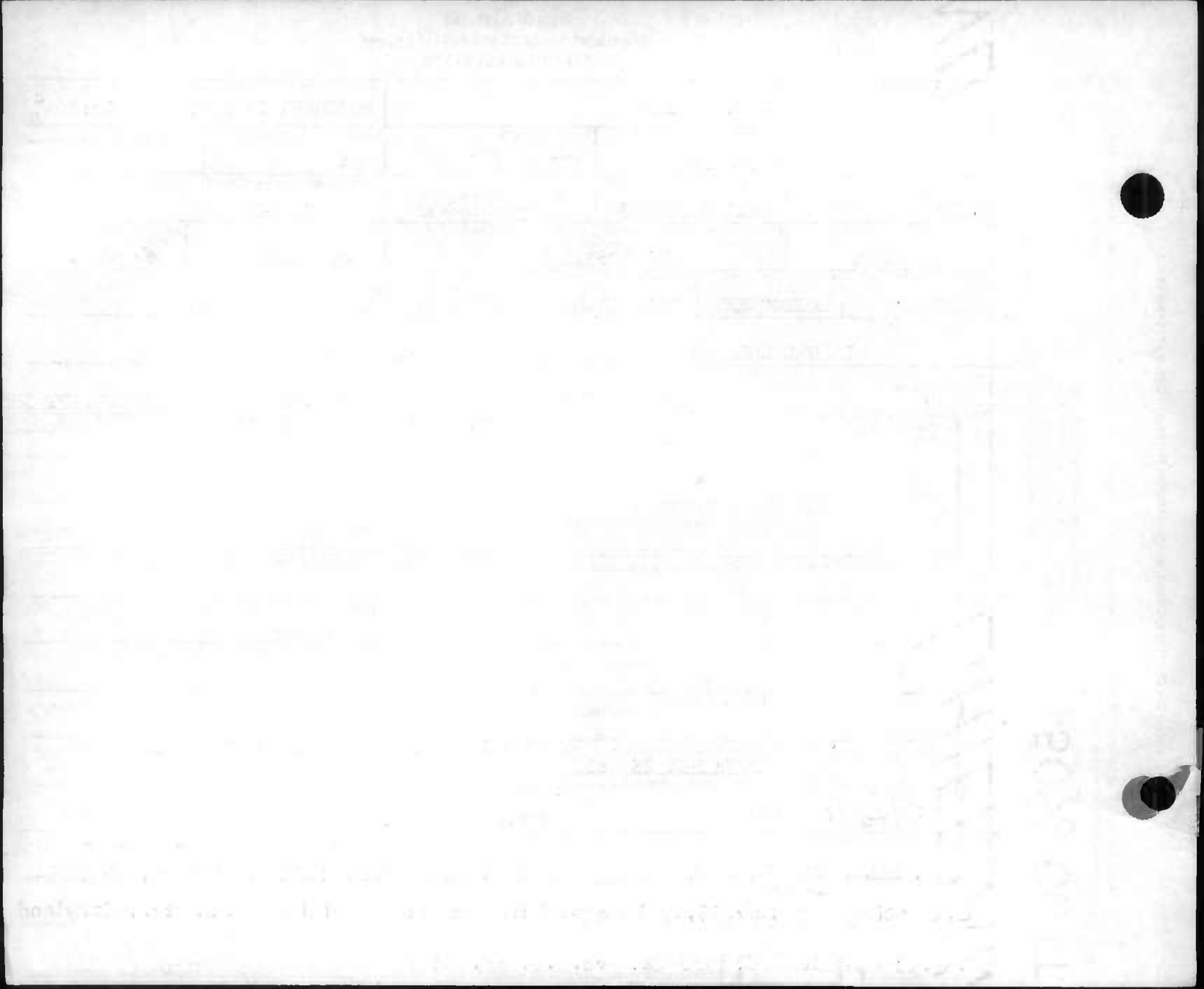


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HARRIET C. DOBIE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 28 1983</b>		2b. HOUR MIN. <b>12:30 a</b>
3. SEX <b>FEMALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>APRIL 25 1889</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>94</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>UTAH</b>	7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>	13c. CITY OR TOWN <b>ROCKVILLE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>299 HURLEY AVENUE</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>LEMUEL COLBATH</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CARRIE SIMON</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>566-30-5461</b>		17. INFORMANT ADDRESS <b>JANE DOHERTY, 3705 S. GEORGE MASON DRIVE, APT 905</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PERITONITIS</b> <b>5679</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF			FALLS CHURCH, VA 22041 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 15, 19 83</b> , to <b>NOVEMBER 28, 19 83</b> , that (I) (we) last saw the deceased alive on <b>NOVEMBER 28, 19 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>L. Hall, Lt. MC, USNR</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>28 Nov 83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>L. HALL, LT. MC, USNR</b>		22e. ADDRESS <b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>	23b. DATE <b>Nov. 29, 1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematry</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland P. G. City, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>W. W. CHAMBERS CO. 8655 Ga. Ave. S. S. Md. 20910</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 01 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

30557

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>THOMAS FRANCIS DORE</b>						2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>11 20 83</b>				2b. HOUR 1:20pm	
1. SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 19 21</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>61 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>	IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>11 20 83</b>				2d. HOUR <b>1:20pm</b>	
3a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery county</b>				MD.	
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Custodian</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Public School</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>PMG</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>804 Chillum Rd</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas F. Dore</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Cooney</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>578-18-0675</b>		17. INFORMANT <b>Josephine T. Dore Wife Same as 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4149 IMMEDIATE CAUSE (a) Coronary Artery Disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Richard L. Whelton</b>				TITLE (PRINT) <b>Deputy Medical Examiner</b>				DATE SIGNED <b>Nov 20, 1983</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>RICHARD L. WHELTON</b>				ADDRESS <b>200 Baltimore College Park</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 23 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>			
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b> ADDRESS <b>500 University Blvd., W. Silver Spring, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 25 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>			

Chicago, Ill.

Wm. L. Sullivan  
1000 North Dearborn St.  
Chicago, Ill.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 30558			
1. FOR STATE REGISTRAR				1. DECEASED NAME			
FIRST <i>Rosa</i> MIDDLE <i>Gloria</i> LAST <i>Dove</i>				2a. DATE OF DEATH MONTH DAY YEAR			
(TYPE OR PRINT) <i>Rosa g Dove</i>				11 11 83			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		Caucasian		MONTH DAY YEAR		72 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Switzerland		U.S.A.				Montgomery MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Takoma Park		Washington Adventist Hospital		Teacher		Public Schools	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?			
13a. STATE 13b. COUNTY 13c. CITY OR TOWN				13e. STREET ADDRESS			
Md. 20912 Mont. Takoma Park				YES <input type="checkbox"/> NO <input type="checkbox"/> 7313 Maple Ave. 20912			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Karl Schwager				Anna Gnehm			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.			
No				213-38-2075			
17. INFORMANT ADDRESS				Richard C Dove., Same as item 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:							6 days.
IMMEDIATE CAUSE (a) <i>4960 Respiratory Failure</i>							
DUE TO, OR AS A CONSEQUENCE OF, (b) <i>Chronic obstruction pulmonary disease</i>							10 years.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO, OR AS A CONSEQUENCE OF, (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
<i>Congestive Heart Failure</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/5, 1983, to 11/11, 1983, that (I) (we) last saw the deceased alive on 11/11, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
<i>Keith M. Lindgren</i>						11/11/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
KEITH M. LINDGREN MD.				7600 Carroll Ave., Takoma Park, Md. 20850			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		11/15/1983		Rock Creek Cemetery		Washington, D.C.	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			
Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., D.C.				NOV 17 1983 <i>John J. Gawler</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 30559	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Ruth S. Durno</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>11/29/83</b>		2b. HOUR <b>6:00 P.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 3, 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Rockville Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary Ret.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>MD 20852</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4 Lorraine Ct. 20852</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Steadman</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillian Meyers</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>218-38-8335</b>		17. INFORMANT ADDRESS <b>Joan Bradfield Same as item # 13</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Severe Cachexia - Debilitation</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Vascular Accident - Left sided</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Paralysis</b> Approximate interval between onset and death <b>3 months</b> <b>6 Months</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Hypertension</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 1976</b> , to <b>11/29/83</b> , that (I) (we) last saw the deceased alive on <b>Nov 19 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>J. Neill Kennedy, M.D.</b>				DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>11-29-83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. Neill Kennedy, M.D.</b>				22e. ADDRESS <b>1145 19th St., N.W. Washington, D.C. 20036</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/2/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l. Cem.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington, VA</b>			
24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Son's Inc.</b>				ADDRESS <b>5130 Wisconsin Avenue N.W., Washington, D.C.</b>				25a. DATE REG'D BY REGISTRAR <b>DEC 5 1983</b>			
				25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician a copy should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Diana Dworkin</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 7 83</b>		2b. HOUR <b>0847A</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>APRIL 29, 1909</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b>		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON, DC</b>		8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY</b>		10. CITY OR TOWN OF DEATH <b>ROCKVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist Hospital</b>		
12a. USUAL OCCUPATION (11. INDUSTRY FOR MOST OF WORKING LIFE) <b>CLERK</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>US GOVERNMENT</b>		13. STREET ADDRESS / ZIP CODE <b>6121 MONTROSE ROAD 20852</b>		
13a. MARYLAND		13b. MONTGOMERY		13c. ROCKVILLE		
14. FATHER'S NAME FIRST MIDDLE LAST <b>KALMAN DWORKIN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNA LIPSCHITZ</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		
16b. SOCIAL SECURITY NO. <b>577-48-3878</b>		17. INFORMANT <b>1471 ROXANNA ROAD, N. W. HARRY KLAVAN, WASHINGTON, D. C.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>DIABETES MELITUS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CHRONIC RENAL FAILURE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>		<b>20 yrs</b>		<b>1 year</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):						
19a. DATE OF OPERATION <b>2</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>9</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <b>OCT 20</b> , 19 <b>83</b> , to <b>Nov 7</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>Nov 7</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <b>Stephen M. Heilman</b> MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22c. DATE SIGNED <b>11/7/83</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>STEPHEN HEILMAN</b>		22e. ADDRESS <b>6246 MONTROSE RD ROCKVILLE, MD 20852</b>		
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>11/8/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL CAPITOL HEBREW CEMETERY</b>		
23d. LOCATION <b>CAPITOL HEIGHTS, PRINCE GEO.</b>		24. FUNERAL DIRECTOR <b>DONALD M. STEIN</b>		25. DATE REC'D. BY REGISTRAR <b>NOV 14 1983</b>		
26. REGISTRAR'S SIGNATURE <b>James J. Conner</b>		27. REGISTRAR'S NAME <b>JAMES J. CONNER</b>		28. REGISTRAR'S ADDRESS <b>232 CARROLL STREET, N. W., WASHINGTON, D. C.</b>		

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 30561	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EMMETT C. DYE</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>November 27, 1983</b>	
2b. HOUR <b>12:54 pm</b>		3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>	
5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 11, 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b>		7. IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>South Dakota</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Structural Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Defense Dpt.</b>		13a. STREET ADDRESS <b>17340 Quaker Lane</b>	
13b. CITY OR TOWN <b>Montgomery</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. ZIP CODE <b>20860</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Olinthus Trippett Dye</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie Harker</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input checked="" type="checkbox"/> OR UNKNOWN <input type="checkbox"/>	
16b. SOCIAL SECURITY NO. <b>159 18 6714</b>		17. INFORMANT <b>Emmett C. Dye Jr.,</b>		ADDRESS <b>3703 Sprucedale/Ann., Va.</b>	
18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of lung</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Alzheimer disease</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Alzheimer disease (20 years)</b>					
19a. DATE OF OPERATION <b>1629</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Alzheimer disease</b>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <b>October 6, 1983</b> to <b>November 27, 1983</b> , that (I) (we) lost saw the deceased alive on <b>November 26, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.		22b. SIGNATURE <b>C. Feinstein MD</b>	
22c. DATE SIGNED <b>11 28 83</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CLAUDE FEINSTEIN</b>		22e. ADDRESS <b>18111 Prince Philip drive Olney Md</b>	
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>Nov. 30, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	
23d. LOCATION <b>Arlington, Va.</b>		23e. COUNTY <b>VA.</b>		23f. STATE <b>VA.</b>	
24. FUNERAL DIRECTOR'S NAME <b>Daves-Pearson Funeral Homes</b>		24b. ADDRESS <b>Arlington, Va. 22201</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 01 1983</b>	
25b. REGISTRAR'S SIGNATURE <b>Jan J. Connel</b>		25c. COUNTY <b>VA.</b>		25d. STATE <b>VA.</b>	

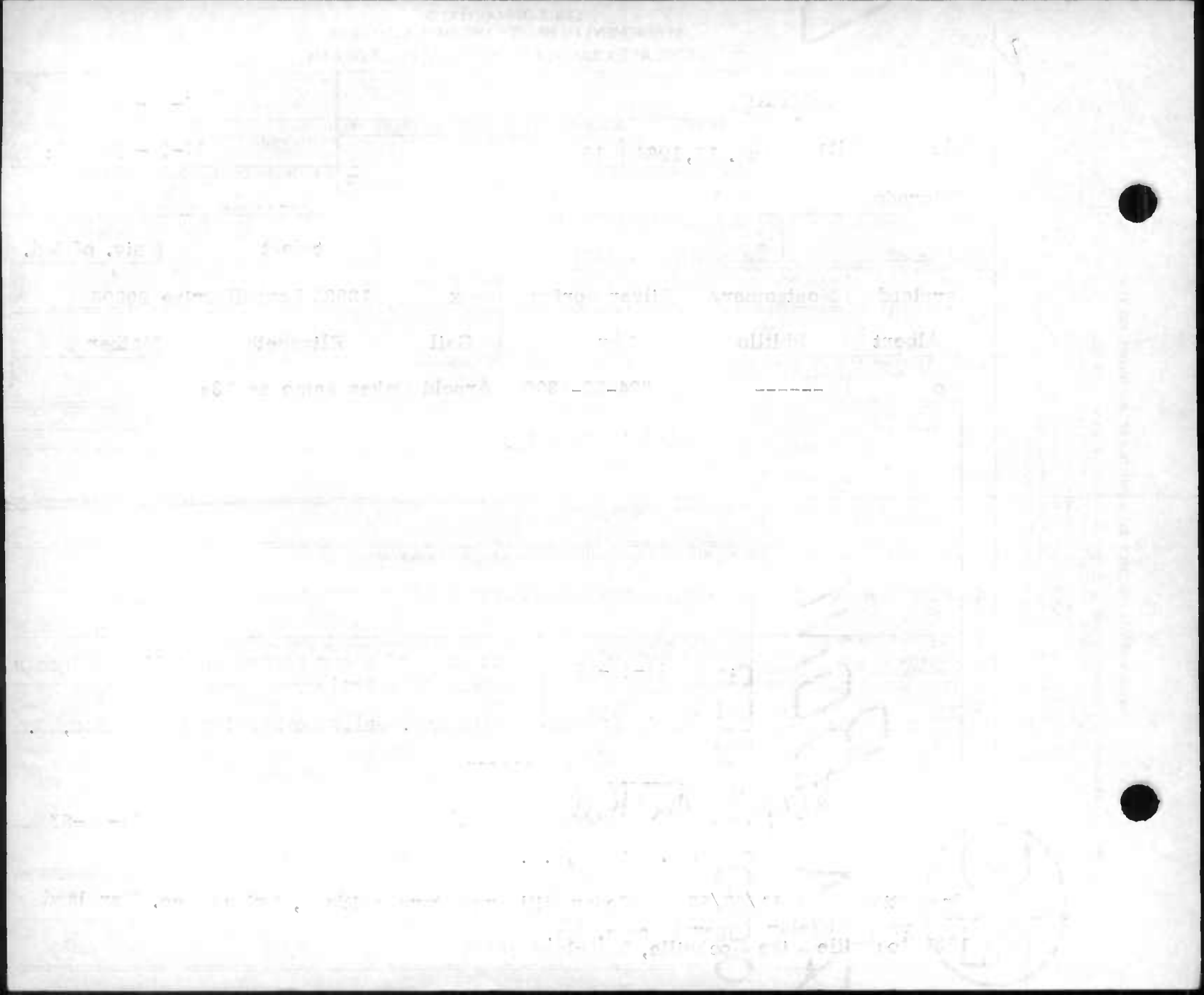


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										30562 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>GREGORY DAVID EHR</b>						2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> <b>11-19-83</b>		2b. HOUR <b>3:20A</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Apr. 15, 1964</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>19</b> YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>11-19-83</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Colorado</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Univ. of Md.</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>13335 Foxhall Drive 20906</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Albert Phillip Ehr</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Gail Elizabeth Mather</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>224-90-7300</b>		17. INFORMANT ADDRESS <b>Arnold Oakes same as 13e</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>8101 Multiple injuries</b> IMMEDIATE CAUSE (a) <b>Multiple injuries</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>2:40A.M. 11-19-83</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>occupant of a car parked on railroad tracks struck by a train</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>railroad tracks</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Howard Ave. Railroad Station Kensington, Md.</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Margie McNeill</b>				TITLE (SPECIFY) <b>M.D. Assistant</b>				DATE SIGNED <b>11-20-83</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>				ADDRESS <b>111 Penn Street</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>11/23/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory Suitland, Prince Geo. Maryland</b>				23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL HOME <b>Tyson Wheeler Funeral Home, Inc.</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 25 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>			
ADDRESS <b>1331 Rockville Pike Rockville, Maryland 20852</b>											

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30563

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Katherine M. Ehrman			2a. DATE OF DEATH MONTH DAY YEAR November 24, 1983		2b. HOUR 4:40p M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 11 1 96		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 20817 5925 Anniston Road
14. FATHER'S NAME FIRST MIDDLE LAST Frederick Moeller		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caroline Beyer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-206804		17. INFORMANT Daughter Gladys C. Roser Same item 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3310 Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) Multiple Aortic and Coronary DUE TO, OR AS A CONSEQUENCE OF (c) Alzheimer's Disease.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 DAYS YEARS YEARS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Nov 14, 1983, to Nov 24, 1983, that (I) (we) lost saw the deceased alive on Nov 24, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.					
22b. SIGNATURE Eugene P. Flannery MD		DEGREE MD		22c. DATE SIGNED 11/25/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE P. FLANNERY, MD		22e. ADDRESS 1811 PRINCE PHILIP DR. OLNEY, MD. 20832			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE NOV. 29, 1983	23c. NAME OF CEMETERY OR CREMATORY Maple Grove Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Richmond Hill, New York	
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND			25a. DATE REC'D. BY REGISTRAR NOV 28 1983		
			25b. REGISTRAR'S SIGNATURE John J. Carver		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

RECEIVED  
OFFICE OF THE  
DIRECTOR OF THE  
BUREAU OF THE  
CENSUS

1-102

November 21, 1902

Washington, D. C.

Mr. J. M. Smith  
Department of the Interior  
Washington, D. C.

Very respectfully,  
J. M. Smith

Yours,  
J. M. Smith

100

100

100

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Medical Examiner Approved (Dr. Maley)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30564

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST KATHERINE MARTHA ELLIS		MONTH DAY YEAR NOVEMBER 22 1983	
2b. HOUR 7:45 P M			
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH JUNE 3 DAY 1904	6. AGE (IN YEARS LAST BIRTHDAY) 79
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY		MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. STATE MD.		13b. COUNTY Montgomery	13c. CITY OR TOWN Chevy Chase
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5302 KENWOOD AVENUE 20845	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM JOHNSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RACHAEL LEAPLEY	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-48-5468	
17. INFORMANT George J. Ellis		ADDRESS Same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes 25 Years +
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>About 1950</b> , 19____, to <b>November</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>September</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>John F. Finnegan</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED 11/23/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN F. FINNEGAN MD		22e. ADDRESS 1150 Varnum St. NE Washington, D.C. 20017	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE Nov. 25, 1983	
23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Mont. Md.	
24. FUNERAL DIRECTOR NAME Joseph Gawlers Sons		ADDRESS 5130 Wisc. Av. Wash., DC	
25a. DATE REC'D. BY REGISTRAR NOV 28 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>	

WORLD JOURNAL, WASHINGTON, D.C., MAY 1962

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Joseph G. ...

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210-46-7468 George J. ...

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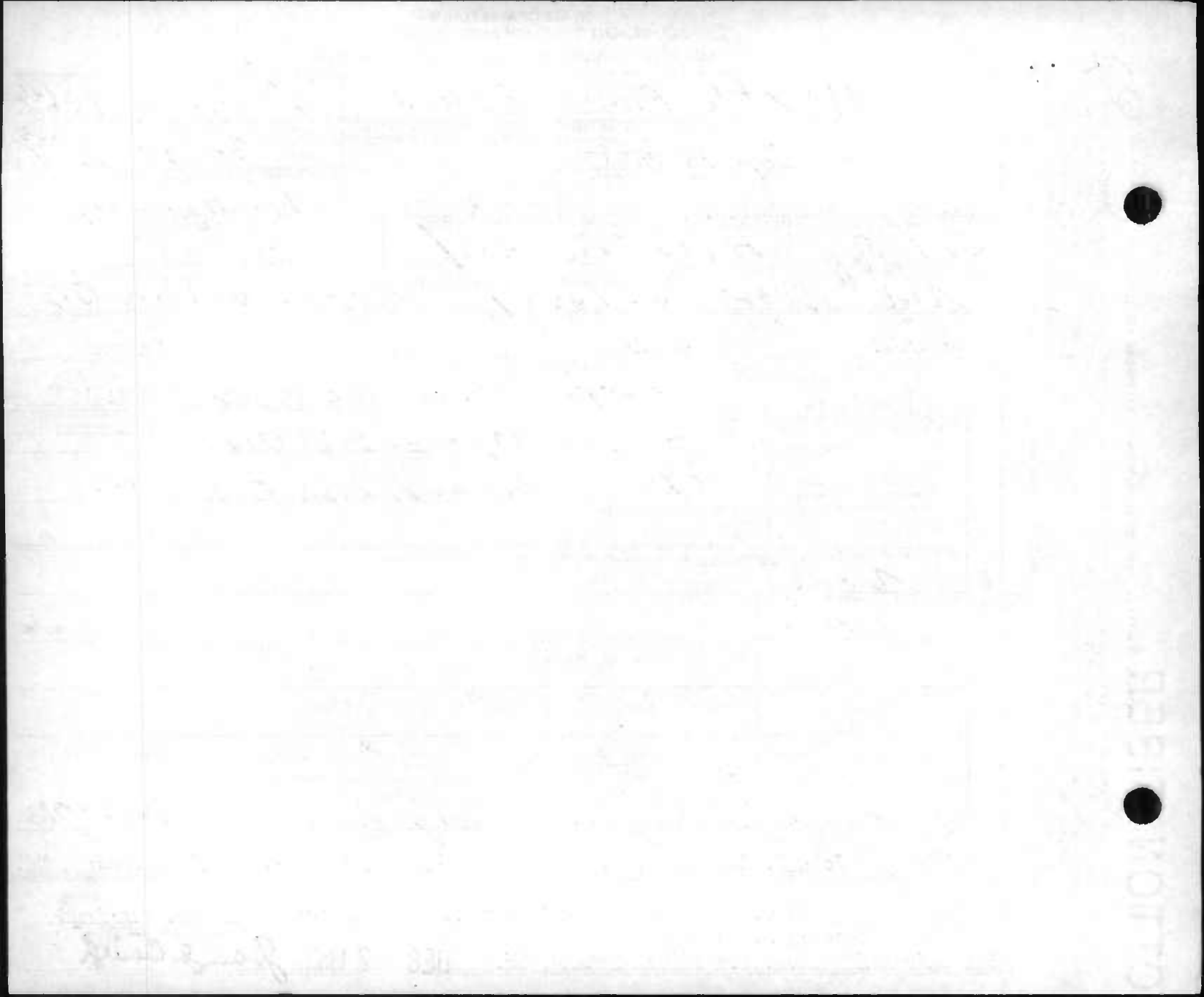
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REG. NO.

### MEDICAL CERTIFICATION

BP\_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
20M 4/82



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				20. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret Mary Fairnill				20. DATE OF DEATH MONTH DAY YEAR 11-1-83			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 02 28 01		6. AGE (IN YEARS LAST BIRTHDAY) YRS 82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.	
10. CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BROOKE GROVE Nsg. Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Wash. DC.				13b. CITY OR TOWN -		13c. STREET ADDRESS 2715 30th ST. S.E. WASH DC.	
14. FATHER'S NAME FIRST MIDDLE LAST James Joseph Cleary				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice I. Thompson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-68-2334T		17. INFORMANT Helen Lingeback		ADDRESS 887 Clopper Rd. Gaithersburg, Md. 20878	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1579 IMMEDIATE CAUSE (a) <u>Pancreatic Carcinoma - Metastatic</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> CAUSE CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF UNDERLYING, NOTIFY MEDICAL EXAMINER) N/A		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR N/A P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A			
21d. INJURY OCCURRED N/A <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A			
22a. I certify that (I) (this hospital) attended the deceased from <u>7/20/83</u> , 19____, to <u>11/1/83</u> , 19____, that (I) (we) lost saw the deceased alive on <u>10-27-83</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Erik B. Young M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-1-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ERIK B. YOUNG M.D.				22e. ADDRESS 20528 GERMANTOWN RD. GERMANTOWN MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/4/83		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL DIRECTOR Gartner Sandison F.H.				316 E. Diamond Ave., Gaithersburg, Md. 20877		25a. DATE REC'D BY REGISTRAR NOV 7 1983	





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30567

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rose T. Feher			2a. DATE OF DEATH MONTH DAY YEAR November 25, 1983		2b. HOUR 7:20P M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR May 9, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hungary	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner	12b. KIND OF BUSINESS OR INDUSTRY Delicatessen	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Kensington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 11206 Waycross Way Zip: 20895	
14. FATHER'S NAME FIRST MIDDLE LAST Louis Tefenhat		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susanna Raiz			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 578-46-8350		17. INFORMANT ADDRESS Margaret A. Spontak, Niece, Same as #13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

4280  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

MEDICAL CERTIFICATION

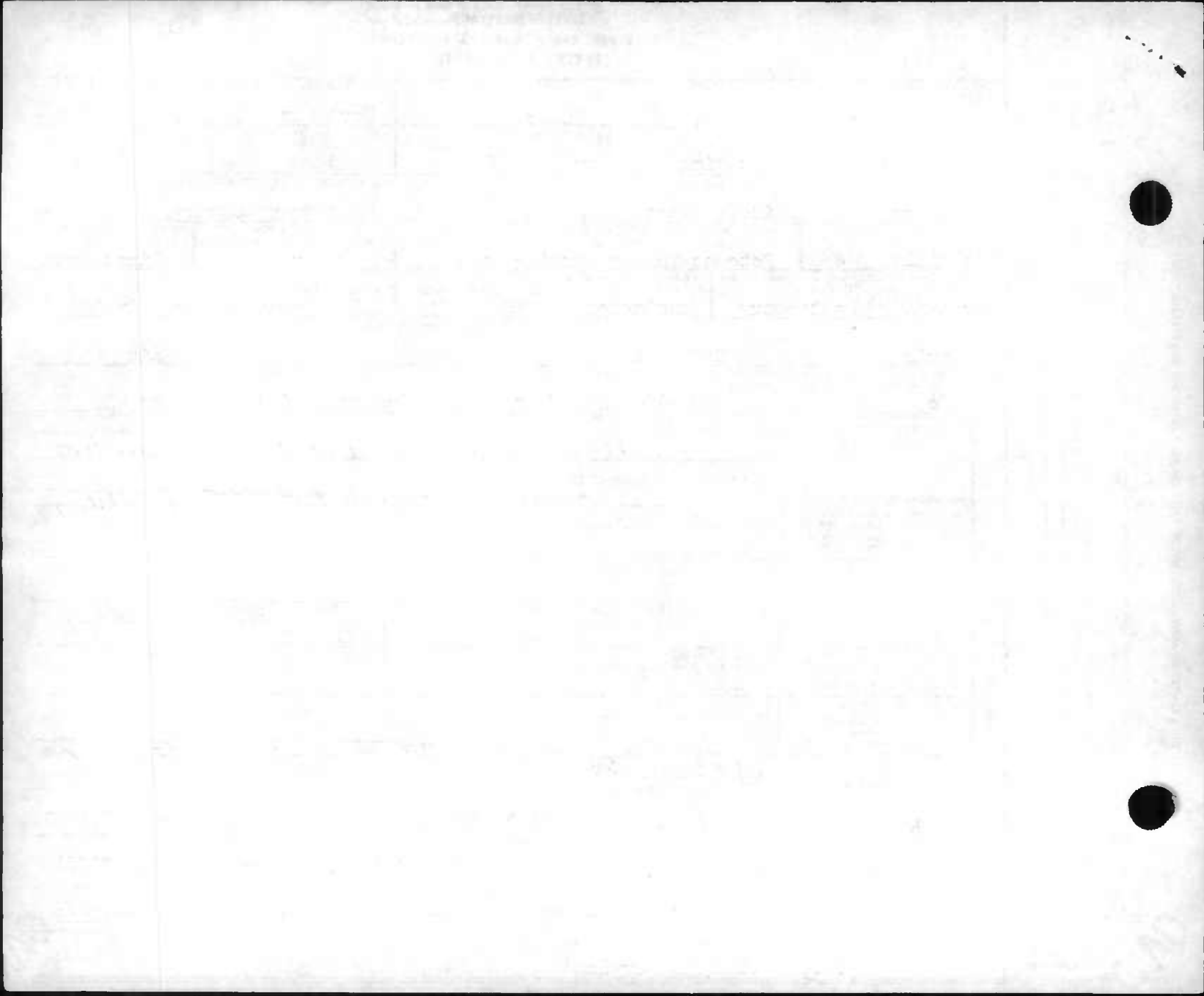
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 79, to 11/23, 19 83, that (I) (we) last saw the deceased alive on 11/23, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE Frauke Westphal		DEGREE MD		22c. DATE SIGNED Nov. 26, 1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frauke Westphal, M.D.		22e. ADDRESS 809 Veirs Mill Rd., Rockville, MD. 20851			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Nov. 28, 1983	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland		25a. DATE REC'D. BY REGISTRAR NOV 28 1983	25b. REGISTRAR'S SIGNATURE John J. Linnick

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Jerome I. Feingold			2a. DATE OF DEATH MONTH DAY YEAR November 11, 1983		2b. HOUR 4:00AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 28, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Vice-Pres. (Ret)		12b. KIND OF BUSINESS OR INDUSTRY Mens Clothing
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 4714 Bartram Street 20853	
14. FATHER'S NAME FIRST MIDDLE LAST Max Feingold		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena Pakifman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW 11 089-12-0384		17. INFORMANT Rockville, Md. Lillian Feingold; 4714 Bartram St.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary Arrest  
 4/00 DUE TO, OR AS A CONSEQUENCE OF  
 (b) Coronary Artery Disease  
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  
 DUE TO, OR AS A CONSEQUENCE OF  
 (c) Acute Atherosclerosis of M.I.

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

3 weeks

3 weeks

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/20</u> , 19 <u>83</u> , to <u>11/7</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>11/7</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If true, (I) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE		22c. DATE SIGNED <u>11/11/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Daniel Goldberg, M.D.		22e. ADDRESS 10401 Old Georgetown Rd Bethesda, Md.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11-13-1983	23c. NAME OF CEMETERY OR CREMATORY Judean Memorial Gardens	23d. LOCATION CITY OR TOWN COUNTY STATE Olney, Maryland
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike		25a. DATE REC'D. BY REGISTRAR 11/17/83	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10% COTTON

Handed over to the ...

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>HORACE J. FELDMAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 23 83</b>			2b. HOUR <b>1:26 PM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 16 1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Subject Cataloger Congress</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Library of</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md. 20816</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5604 Marengo Road 20816</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Max Feldman</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Fannie Volpin</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW1</b>		17. INFORMANT <b>Anita Feldman. Same as item 13</b>		ADDRESS			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Pulmonary arrest.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4349 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Brain Stem infarction.</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Massive infarction in Brain.</b>			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11/21/83</b> 19 <b>83</b> , to <b>11/23/</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>11/23/</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>M.D. Khoury</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HIRSH-D. KHOURY</b>		22e. ADDRESS <b>20428 Gemenstown Rd, Gemenstown MD 20874</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>11/25/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland Maryland</b>	
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24. FUNERAL DIRECTOR NAME ADDRESS <b>Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., D.C.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canine</b>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

2100 Ave. N.W., Wash., D.C.  
Joseph Gaudin's Sons Inc.  
Attention 11/25/1963 Central Mail Laboratory Building Building

*Handwritten notes:*  
1. 11/25/1963  
2. 11/25/1963  
3. 11/25/1963

Yes Will 306-07-7862 White Telephone. Same as item 13

Telexman Yankie

Volpin

Ms. 50816 Montgomery Technika 500+ Marcano Road

Subject Cataloger

New Jersey U.S.A.

Male White Age 16 1959 64

Horace J. Telexman

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Glen NMI Fildes			2a. DATE OF DEATH MONTH DAY YEAR November 22, 1983		2b. HOUR 12:10PM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR March 6 1908		6. AGE (IN YEARS LAST BIRTHDAY) 75	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rockville Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manual Therapy		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Dane Fildes			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura E. Hosselton		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 346-12-7421		17. INFORMANT ADDRESS Dorothea Fildes, 13539 Georgia Ave., #202 Silver Spring, MD 20906	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory arrest</u> <u>4340</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. b) <u>Cerebral arteriosclerosis + thrombosis</u> c) <u>Generalized arteriosclerosis</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30'</u> <u>1 yr.</u> <u>5 yrs</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a) <u>Parkinsonian tremor</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/15/83</u> to <u>11/22/83</u> , that (I) (we) last saw the deceased alive on <u>11/15/83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Stephen N. Jones</u>		DEGREE		22c. DATE SIGNED <u>11/22/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen N. Jones, M.D.		22e. ADDRESS 809 Veirs Mill Road Rockville, MD 20850			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov 25, 1983	23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Maryland
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. 7557 Wisconsin Ave., Bethesda, Maryland 20814		25a. DATE REC'D. BY REGISTRAR NOV 28 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Lamer</u>	

RECEIVED  
JAN 10 1910  
U.S. DEPT. OF AGRICULTURE  
WASHINGTON, D.C.

TO THE SECRETARY OF AGRICULTURE  
WASHINGTON, D.C.

FROM  
J. H. HARRIS  
1010 15th St. N.W.  
WASHINGTON, D.C.

Dear Sir:  
I have the honor to acknowledge the receipt of your letter of the 10th inst. regarding the matter of the proposed amendment to the act of March 3, 1879, relating to the collection of the duties on foreign-made goods.

I am sorry to hear that you are unable to attend the meeting of the committee on the 15th inst. I am sure that your presence would have been of great value to the committee. I am sure that you will be able to attend the meeting of the committee on the 22nd inst. I am sure that your presence will be of great value to the committee.

Very respectfully,  
J. H. HARRIS  
1010 15th St. N.W.  
WASHINGTON, D.C.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Julius J. Firestone</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>01/16/83</b>		2b. HOUR <b>2001 M</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 24, 1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>	
10. CITY OR TOWN OF DEATH <b>Gaithersburg</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Owner (Ret.)</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Dry Cleaner</b>	
13a. STATE <b>Florida</b>	13b. COUNTY <b>Dade</b>	13c. CITY OR TOWN <b>Miami Beach</b>	13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>8955 Collins Avenue</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Firestone</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Gussie Beck</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>098-14-4108</b>		17. INFORMANT ADDRESS <b>Ron Lehrke; 1920 Alton Road, M Beach Florida</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4100 ACUTE MYOCARDIAL INFARCTION</b> IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) <b>CORONARY HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>75 MIN.</b> <b>10 + YEARS</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/15</b> , 19 <b>83</b> , to <b>11/16</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>11-15</b> , 19 <b>83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE <b>Joel A. Reiskin, MD</b>		DEGREE		22c. DATE SIGNED <b>11-17-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOEL A. REISKIN, MD</b>		22e. ADDRESS <b>50 W. EDMONSTON DR., ROCKVILLE MD 20852</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>11-20-1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Nebo Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Miami, Florida</b>	
24. FUNERAL DIRECTOR NAME <b>Danzansky-Goldberg Chapels; 1170 Rockville Pike</b>		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>John J. Grief</b>	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>MARIA SORROCO FISHER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 28 1983</b>		2b. HOUR <b>6:19 a</b>
3. SEX <b>FEMALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>OCTOBER 25 1942</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>41</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>SPAIN</b>	7b. CITIZEN OF WHAT COUNTRY? <b>SPAIN</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>
13a. STATE <b>PENNSYLVANIA</b>		13b. COUNTY <b>MONTGOMERY</b>	13c. CITY OR TOWN <b>NORRISTOWN</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>1004 WILLOW STREET</b> <b>99999</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>GORGIO ALVAREZ GARCIA</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>182-56-1224</b>		17. INFORMANT ADDRESS <b>AMBROSE C. FISHER, 1004 WILLOW STREET,</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

3989 IMMEDIATE CAUSE (a) **RHEUMATIC HEART DISEASE**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>AUGUST 25</b> , 19 <b>83</b> , to <b>NOVEMBER 28</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>NOVEMBER 28</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>[Signature]</i> MD		22c. DATE SIGNED <b>29 NOV 83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>TOMAS, CONCEPCION, LT, MC, USNR</b>		22e. ADDRESS <b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>	23b. DATE <b>Nov. 29, 1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, P. G. Cty., Maryland</b>
24. FUNERAL DIRECTOR NAME <b>W. W. CHAMBERS CO., 8655 Ga. Ave. S. S. Md. 20910</b>		25. DATE RECEIVED BY REGISTRAR <b>DEC 01 1983</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED  
U.S. AIR FORCE  
1954



NAME		GRADE		DATE	
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853	854	855	856	857	858
859	860	861	862	863	864
865	866	867	868	869	870
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937	938	939	940	941	942
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949	950	951	952	953	954
955	956	957	958	959	960
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967	968	969	970	971	972
973	974	975	976	977	978
979	980	981	982	983	984
985	986	987	988	989	990
991	992	993	994	995	996
997	998	999	1000	1001	1002

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST W. Willis Fisher			2a. DATE OF DEATH MONTH DAY YEAR 11/14/83		2b. HOUR 845 P M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 9 / 6 / 10		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.		
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		
14. FATHER'S NAME FIRST MIDDLE LAST William N. Fisher		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isabel Dodge		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Agent		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 215-44-8118		17. INFORMANT Son Stephen W. Fisher		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 12401 Village Square Terrace		20852		
16c. ADDRESS 1936 Mt. Royal Ter. Baltimore, Md. 21217		17. INFORMANT Son Stephen W. Fisher		17. INFORMANT Son Stephen W. Fisher		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEPATIC ENCEPHALOPATHY</u> 5715 DUE TO, OR AS A CONSEQUENCE OF (b) <u>HEPATIC CIRRHOSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>11/14</u> 19 <u>83</u> to <u>11/14</u> 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>11/14</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.						
22b. SIGNATURE <u>Mark H. Elg</u>		DEGREE		22c. DATE SIGNED 11/15/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK H. ELG		22e. ADDRESS 9801 Georgia Ave, Silver Spring, Md		22f. DATE SIGNED 11/15/83		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 17, 1983		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Ph. Geo. Md.		23e. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23f. LOCATION CITY OR TOWN COUNTY STATE Suitland Ph. Geo. Md.		
24. FUNERAL DIRECTOR NAME Francis J. Collins		24b. ADDRESS 500 University Blvd., W. Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR NOV 21 1983		
24c. NAME Francis J. Collins		24d. ADDRESS 500 University Blvd., W. Silver Spring, Md.		25b. REGISTRAR'S SIGNATURE <u>John J. Gierke</u>		

BP

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

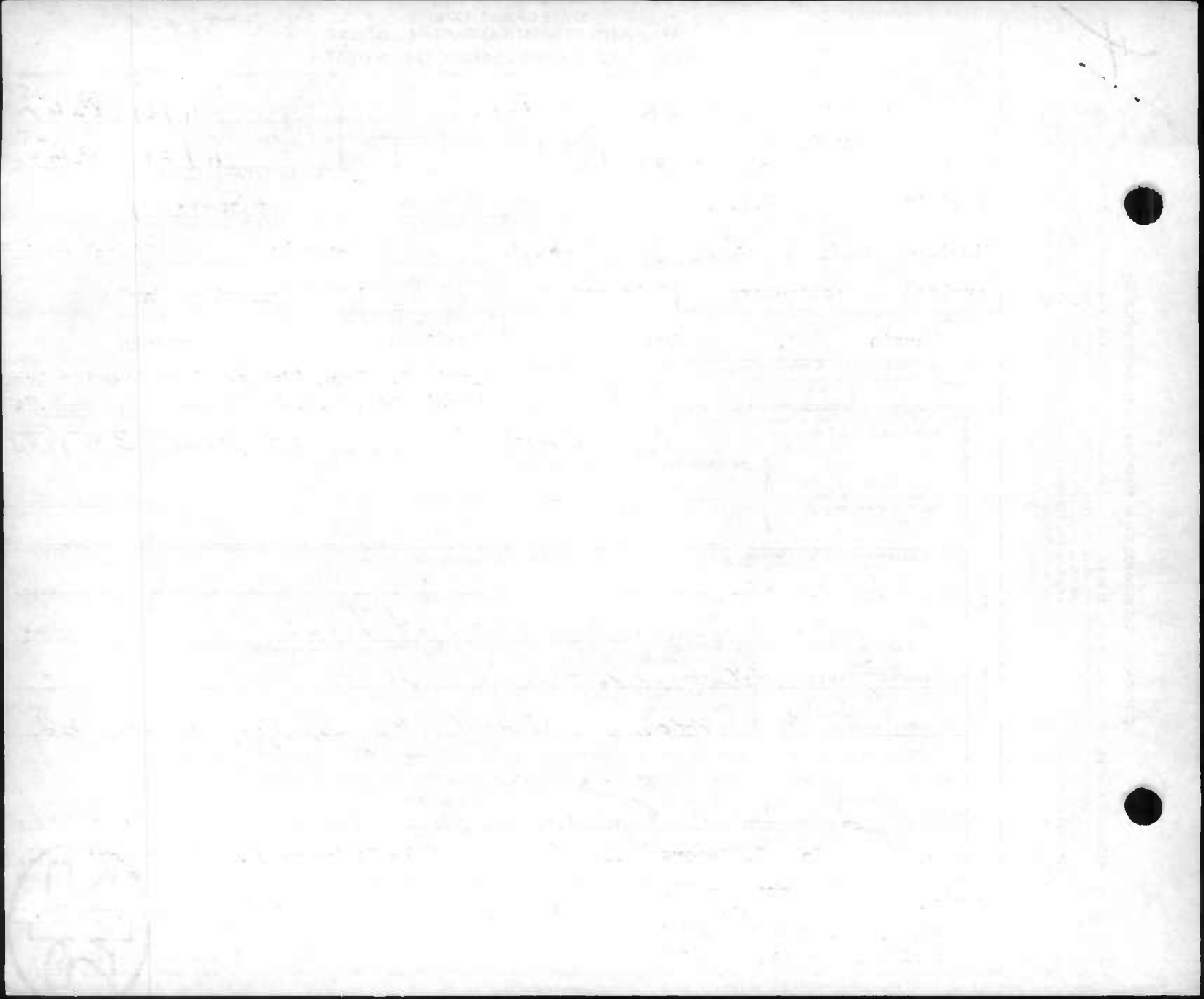
DHMH - 17  
(VR A15 ME (1))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30574

REG. NO.

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE OF DEATH		2d. HOUR	
Timothy Patrick Flynn		11/21 1983		10:45 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.
MALE	Caucasian	2 26 63	20 YRS.		
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9b. CITIZEN OF WHAT COUNTRY?	10. MARRIED	11. NEVER MARRIED	12. DIVORCED	13. BALTIMORE CITY OR COUNTY OF DEATH
Virginia	U.S.A.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Montgomery
14. CITY OR TOWN OF DEATH	15. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	16a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	17b. KIND OF BUSINESS OR INDUSTRY		
Bethesda, MD	Suburban Hosp.	Mechanic	Diesel engine		
18a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	18b. STATE	18c. COUNTY	18d. CITY OR TOWN	18e. STREET ADDRESS	18f. ZIP CODE
Maryland	Montgomery	Gaithersburg	13d. INSIDE CITY LIMITS?	19335 Dunnbridge Way	20879
19. FATHER'S NAME	20. MOTHER'S MAIDEN NAME				
Martin J. Flynn	Kathleen H. Hartnett				
21a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	21b. SOCIAL SECURITY NO.	22. INFORMANT	23. ADDRESS		
NO	577 82 5997	Martin J. Flynn (Father)	1848 Wyoming Ave. Washington, D.C. 20009	N.W.	
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY:					
9554 IMMEDIATE CAUSE (a) Gunshot Wound of Head					
DUE TO, OR AS A CONSEQUENCE OF					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
None					
25a. DATE OF OPERATION	25b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	26. AUTOPSY?			
11-28-83	Gunshot wound of head	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
27a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	27b. TIME OF INJURY	27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
	9:20 PM 11/21/83	Shot self			
28a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	28b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	28c. LOCATION	28d. CITY OR TOWN	28e. COUNTY	28f. STATE
	Home	Layhill Rd.	Silver Spring	Montgomery	MD
29a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
29b. TITLE (SPECIFY)					
M.D. Dep					
29c. MEDICAL EXAMINER					
DATE SIGNED Nov 24/1983					
30. ACTUAL SIGNATURE					
31. EXAMINER'S NAME (TYPE OR PRINT)					
John S. Rogers, M.D.					
32. ADDRESS					
1919 Seminary Rd., Silver Spring, Md.					
33a. BURIAL, CREMATION, REMOVAL					
Burial					
33b. DATE					
November 23, 1983					
33c. NAME OF CEMETERY OR CREMATORY					
Neelsville Cemetery, Germantown, Maryland					
33d. LOCATION					
CITY OR TOWN					
Germantown, Maryland					
34. FUNERAL DIRECTOR'S NAME					
Robert A. Pumphrey					
34b. ADDRESS					
Rockville, Maryland 20850					
35. DATE REC'D. BY REGISTRAR					
NOV 23 1983					
36. REGISTRAR'S SIGNATURE					
John J. Connelley					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 30575			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST John Paul Foley Sr.				November 5, 1983			
2b. HOUR 9:45 P.M.							
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 23 1902		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ill.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fernwood House Retirement & Nurs.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Gen. Dep. Director D.C. Gov't.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md. 20834		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 3 Derbyshire Ct.		13f. ZIP CODE 20817		14. FATHER'S NAME FIRST MIDDLE LAST Francis M Foley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katheryne Baujan	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-12-6577		17. INFORMANT Margaret E Foley. Same as item 13.		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Longstanding Heart Failure</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>2 1/4 years</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>April</u> 19 <u>81</u> to <u>10/5</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>10/25</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jack P. Segal		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/6/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JACK P. SEGAL		22e. ADDRESS 5530 Wisconsin Ave.		City, County, State Ch. Chrs. Md. 20815			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/9/1983		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland.	
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons Inc. ADDRESS 5130 Wisc. Ave., N.W. Wash., D.C.				25a. DATE REC'D. BY REGISTRAR NOV 14 1983			
				25b. REGISTRAR'S SIGNATURE John J. Gawler			

*[Faint, illegible handwritten notes]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 30576	
1. DECEASED NAME (TYPE OR PRINT) <b>Mary Elizabeth Ford</b>										2a. DATE KNOWN OF DEATH <b>Nov 6 1983</b>	
2b. DATE ESTIMATED <b>Nov 6 1983</b>										2c. DATE PRONOUNCED DEAD <b>Nov 6 1983</b>	
3. SEX <b>F</b> 4. RACE <b>W</b> 5. DATE OF BIRTH <b>June 5 1929</b> 6. AGE (IN YEARS) <b>54</b> 7. IF UNDER 1 YR. <b>NO</b> 8. IF UNDER 24 HRS. <b>NO</b>										9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b> 11. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> 12. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	
14. CITY OR TOWN OF DEATH <b>Silver Spring, Md.</b> 15. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <b>Bel Pre N. H.</b> 16. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Prince Georges Temple Hills</b>										17. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
18. STATE <b>Md.</b> 19. COUNTY <b>Prince Georges</b> 20. CITY OR TOWN <b>Temple Hills</b> 21. INSIDE CITY LIMITS? <b>YES</b> 22. STREET ADDRESS <b>5943 Fisher Rd. #203</b>										23. CITY OR TOWN <b>Temple Hills, Md.</b> 24. STATE <b>Md.</b>	
25. FATHER'S NAME <b>Charles</b> 26. MOTHER'S MAIDEN NAME <b>Martha Frye</b>										27. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b> 28. SOCIAL SECURITY NO. <b>578-52-0568A</b> 29. INFORMANT <b>Mary V. Ford</b>	
30. ADDRESS <b>5943 Fisher Rd. #203 Temple Hills, Md. 20748</b>										31. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
32. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <b>8842</b> (b) <b>DO NOT WRITE</b> (c) <b>DO NOT WRITE</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Fract. L. Hip</b>											
33. DATE OF OPERATION <b>10-15-83</b> 34. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Fract. L. Hip</b> 35. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>											
36. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH <b>11/5/83</b> 37. TIME OF INJURY <b>11:50 P.M.</b> 38. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Fell out of wheelchair</b>											
39. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <b>NO</b> 40. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>N.H.</b> 41. LOCATION <b>Bel Pre Rd Silver Spring Mont Md.</b>											
42. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
43. ACTUAL SIGNATURE <b>John S. Rogers</b> M.D. <b>Dep</b> MEDICAL EXAMINER DATE SIGNED <b>Nov 6 1983</b>											
44. EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers</b> ADDRESS <b>1919 Seminary Rd. Silver Spring, Md.</b>											
45. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b> 46. DATE <b>11/11/83</b> 47. NAME OF CEMETERY OR CREMATORY <b>Monocacy Cemetery</b> 48. LOCATION (CITY OR TOWN) <b>Beallsville, Maryland</b>											
49. FUNERAL DIRECTOR NAME <b>Tyson Wheeler Funeral Home, Inc.</b> ADDRESS <b>1331 Rockville Pike Rockville, Md. 20852</b> 50. DATE REC'D. BY REGISTRAR <b>NOV 16 1983</b> 51. REGISTRAR'S SIGNATURE <b>John J. Connelley</b>											



30577

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE REGISTRAR		2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR <u>Nov 13, 1983</u>										2b. HOUR OF DEATH <u>5 M</u>																	
1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST <u>Azizollah Fouladi</u>										2c. DATE PRONOUNCED DEAD <u>Nov. 13, 1983</u>		2d. HOUR <u>5 M</u>															
3. SEX <u>M</u>		4 RACE <u>W</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>April 11, 1916</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>67</u> YRS		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Iran</u>		7b. CITIZEN OF WHAT COUNTRY? <u>Iran</u>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery MD.</u>											
10 CITY OR TOWN OF DEATH <u>Potomac</u>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>11410 Gainsborough Rd.</u>								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Self-employed</u>				12b. KIND OF BUSINESS OR INDUSTRY <u>Transportation</u>													
13a. STATE <u>Maryland</u>				13b. COUNTY <u>Montgomery</u>				13c. CITY OR TOWN <u>Potomac</u>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS <u>11410 Gainsborough Rd. 20854</u>													
14. FATHER'S NAME FIRST MIDDLE LAST <u>Nassrolah Fouladi</u>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Marhemat Lessan</u>																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>no</u>										16b. SOCIAL SECURITY NO. <u>None</u>										17. INFORMANT <u>Gaithersburg, Maryland 20877</u> <u>Hossein Fouladi 386 N. Summit Ave.</u>									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Myocardial Dis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																													
19a. DATE OF OPERATION <u>None</u>														19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE																					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion														TITLE (SPECIFY) <u>Doc</u> MEDICAL EXAMINER						DATE SIGNED <u>Nov 13, 1983</u>									
ACTUAL SIGNATURE <u>John S. Rogers</u> M.D.														EXAMINER'S NAME (TYPE OR PRINT) <u>John S. Rogers</u>						ADDRESS <u>Seminary Road, Silver Spring, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				23b. DATE <u>11/19/83</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Tehran Cemetery</u>				23d. LOCATION CITY OR TOWN COUNTY STATE <u>Tehran, Iran</u>																	
24. FUNERAL HOME <u>ALEXANDER S. POPE FUNERAL HOME, 2617 Pennsylvania Ave., S.E. Wash, D.C.</u>														25a. DATE REC'D. BY REGISTRAR <u>NOV 15 1983</u>				25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>											

BP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5))  
20M 4/82

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



2517 Pennsylvania Ave., N.W., Wash., D.C.  
ALFRED S. FINE, ATTORNEY

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

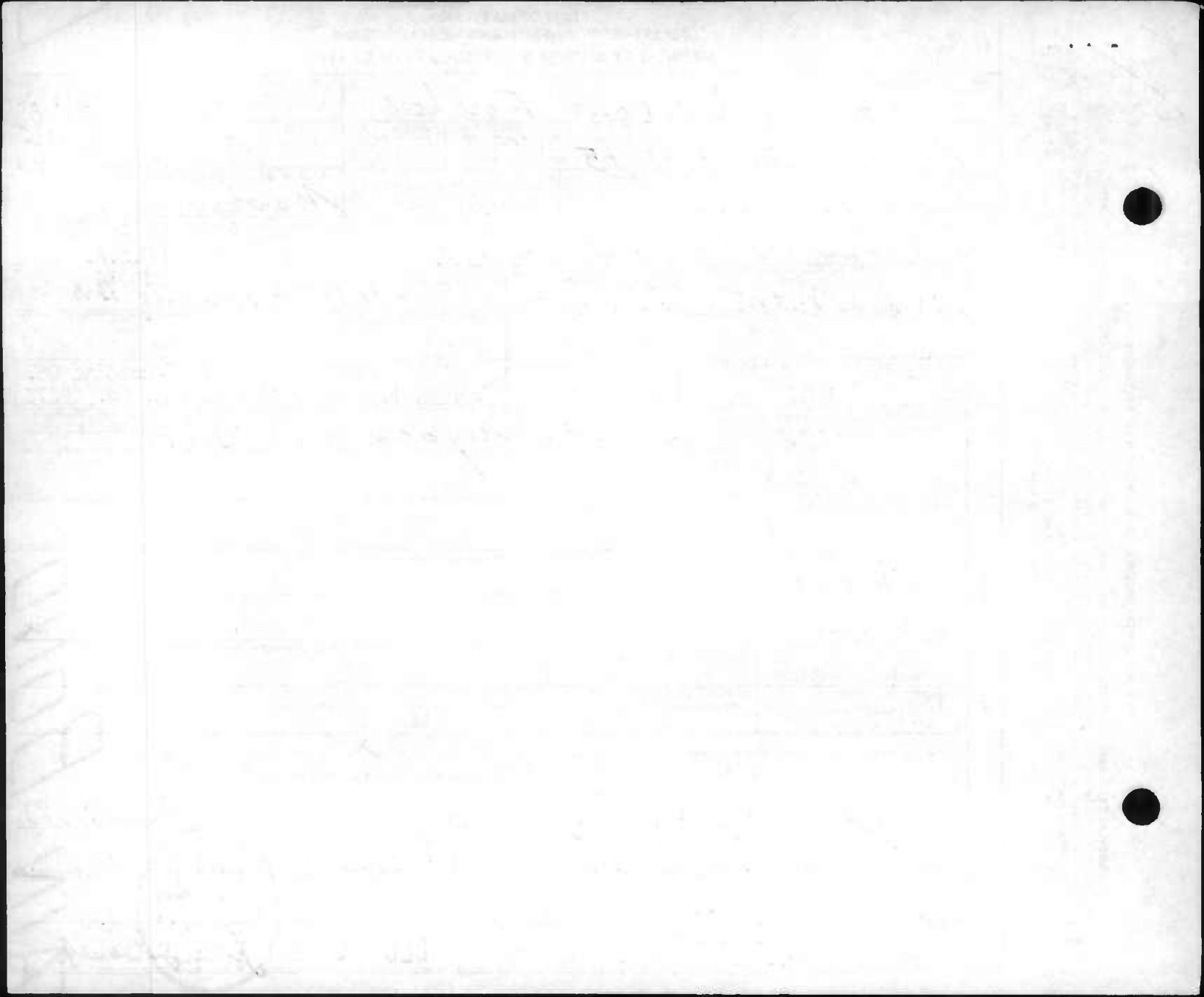
BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT) <b>Edward Vincent Fowler</b>										7a. DATE KNOWN OF DEATH <b>Nov 27 1983</b>				7b. HOUR 10 AM	
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Oct 6 18 65</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>18 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD <b>Nov 27 1983</b>				7d. HOUR 9 AM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.											
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>401 Pershing Dr.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Analyst</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>N.S.A.</b>							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE <b>MD</b>		13b. COUNTY <b>Mont</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>401 Pershing Dr</b>									
4. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown Fowler</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Pearl Unknown</b>													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII</b>		17. INFORMANT <b>Son</b>				ADDRESS <b>10 Fenceline Dr. Gaithersburg, Md. 20878</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4291</b> IMMEDIATE CAUSE (a) <b>Acute myocardial Dis</b> Conditions, if any, which } gave rise to immediate } cause (a) stating the under- } lying cause last. } DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
<b>None</b>																	
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE <b>John S. Rogers</b>				TITLE (SPECIFY) <b>Dep</b>				MEDICAL EXAMINER				DATE SIGNED <b>Nov 27 1983</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>				ADDRESS <b>1919 Seminary Road Silver Spring, Md.</b>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Nov. 30, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>George Washington</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Adelphi Pr. Geo. Md.</b>							
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 6 1983</b>				25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>									
500 University Blvd., W. Silver Spring, Md.																	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JAMES W FRAZIER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11/11/83</b>		2b. HOUR MIN. <b>6:45 AM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 16, 1911</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>72</b>		
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUBURBAN HOSP</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONT.</b>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Federal Gov't.</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>C I A</b>			
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Roy - Frazier</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Edna Garrett Frazier</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-03-6934</b>		17. INFORMANT ADDRESS <b>13408 Ridge Rd. Rockville, Md. 20850</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1629 Bronchogenic Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>8/11/83</b> to <b>9/11/83</b> , that (I) (we) last saw the deceased alive on <b>9/11/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Joel Schelman</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9/11/83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Joel Schelman</b>		22e. ADDRESS <b>9410 Old Georgetown Rd. Bethesda 20814</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Nov. 11, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematory</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Gartner Sandison Funeral Home 316 E. Diamond Ave. Gaithersburg, Md. 20878</b>				
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>James G. Gainer</b>				

BP

Bookville, N.Y. 30850  
1300 Ridge Rd.  
Larchmont, N.Y.

25. 6. 1941. 50451

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Prof. Dr. G. A. S. 1967

SECRET

• D. C. •

1. *Handwritten signature*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>FLORENCE L. FREEMAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOV 23 83</b>		2b. HOUR <b>7:15 PM</b>
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 27 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Massachusetts</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carriage Hill Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Silver Spring</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3374 Chiswick Court # 2-D</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Logue</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Josephine Wilkin</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>029-09-8890</b>		17. INFORMANT <b>Niece</b> ADDRESS <b>914 Wynnwood Road Pelham Manor, N.Y. 10803</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) <b>4340</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiorespiratory failure</b>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>
	DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic vascular disease severe</b>	<b>36 hrs</b>

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  
**Severe coronary artery disease 5/8 MI remote & permanent pacemaker.**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>9/22 19 83</b> , to <b>11/23 19 83</b> , that (I) (we) lost saw the deceased alive on <b>11/23 19 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>James R. Coleman MD.</b>				22c. DATE SIGNED <b>11/23/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES R. COLEMAN</b>				22e. ADDRESS <b>924 COLUMBIA BLVD SILVER SPRING MD. 20910.</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>12/1/83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Malden Middlesex Massachusetts</b>
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b> ADDRESS <b>500 University Blvd., W. Silver Spring, Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>DEC 2 1983</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

*[Faint, illegible handwritten text covering the majority of the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Herbert J. Friedel			2a. DATE OF DEATH MONTH DAY YEAR November 11, 1983		2b. HOUR 3:30 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 17, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Physician		12b. KIND OF BUSINESS OR INDUSTRY Medical
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Sil. Spg.	
14. FATHER'S NAME FIRST MIDDLE LAST Fred Friedel			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jenny Yockel		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OF DATES) WW II 053-18-9720		17. INFORMANT Silver Spring, Maryland Marilyn Friedel; 3530 Twin Branches Drive	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute + Chronic renal failure</u> 4039 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Renovascular occlusive disease</u> (c) <u>4.5 yrs (Chronic)</u> <u>4.5 yrs</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 mth (acute)</u> <u>4.5 yrs (Chronic)</u> <u>4.5 yrs</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Bacterial interstitial pneumonia, lymphoma, hypertension, Adrenal Insuff.</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 11 Nov 83	
22a. I certify that (I) (this hospital) attended the deceased from <u>July 19 83</u> , to <u>11 Nov 83</u> , that (I) <u>last</u> saw the deceased alive on <u>11 Nov 83</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death.					
22b. SIGNATURE <u>Donald E. Dillon</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>11 Nov 83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald E. Dillon, M. D.		22e. ADDRESS 18111 Prince Philip Dr. Olney, Maryland 20832			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11-13-1983	23c. NAME OF CEMETERY OR CREMATORY Judean Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Olney Maryland	
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ELLA OAKLEY FULLEN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 30, 1983</b>		2b. HOUR <b>4:55 PM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>APRIL 9, 1910</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		8. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.		10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUBURBAN HOSPITAL</b>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TYPIST</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOVT.</b>		13a. STREET ADDRESS / ZIP CODE <b>7401 WESTLAKE TERRACE #510 20817</b>		
13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>BETHESDA</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM Z. FULLEN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MINNIE E. FULLEN</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		
16b. SOCIAL SECURITY NO. <b>409-18-3541</b>		17. INFORMANT ADDRESS <b>2933 Prince of Wales Dr. MADELE F. COOLEY, SISTER, Chesapeake, Va.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>METASTATIC CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>MALNUTRITION</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>GASTRIC OUTLET OBSTRUCTION</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 22, 19 83</b> to <b>NOVEMBER 30 19 83</b> , that (I) (we) last saw the deceased alive on <b>NOVEMBER 30, 19 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) examine the body after death.				
22b. SIGNATURE <i>K.S. Kim</i>		DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-30-83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KWANG S. KIM M.D.</b>		22e. ADDRESS <b>11119 ROCKVILLE PIKE, ROCKVILLE, MD. 20852</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>12/6/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GLENCOE CEMETERY</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BIG STONE GAP, WISE, VA.</b>		24. FUNERAL DIRECTOR NAME <b>RICHARD RAPP, INC. WASHINGTON, D.C. 20036</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 6 1983</b>		
25b. REGISTRAR'S SIGNATURE <i>John J. Conish</i>						

MEDICAL CERTIFICATION



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Antoinette Gagliardi</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>19</b> YEAR <b>1983</b>			2b. HOUR <b>7:45 PM</b>					
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>Sept.</b> DAY <b>15</b> YEAR <b>1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10. CITY OR TOWN OF DEATH <b>S.S.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Md.</b>		13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6006 Mervern Drive 20817</b>			
14. FATHER'S NAME FIRST <b>Santo</b> MIDDLE <b></b> LAST <b>Pennestra</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Marin</b> MIDDLE <b></b> LAST <b>Sgro</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>None</b> (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO. <b>579 05 9450</b>		17. INFORMANT <b>2803 Sudberry Lane Bowie, Md.</b> <b>Joseph Gagliardi (Son)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLISM</b> <b>4511</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>DEEP VEIN THROMBOSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>2 SEPT, 19 83</b> to <b>19 NOV 19 83</b> , that (I) (we) last saw the deceased alive on <b>19 NOV 19 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Walter E. Gooch MD</b>				DEGREE				ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/20/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WALTER E. GOOCH MD</b>				22e. ADDRESS <b>4309 SHOREFIELD RD SIL SPR MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>11/25/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION CITY OR TOWN <b>S.S.</b> COUNTY <b>Mont.</b> STATE <b>Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi</b> ADDRESS <b>11800 New Hampshire Ave. S.S. Md</b>						25a. DATE REC'D. BY REGISTRAR <b>3 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Lankish</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>ESTELLA B. GAITHER</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11-30-83</b>				2b. HOUR <b>12:40 A</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>May 7, 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. PLACE OF BIRTH <b>Washington D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.			
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>				12a. OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired SECRETARY</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>PR. GEORGE</b>		13c. CITY OR TOWN <b>Cheverly</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Eustace Greenough</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Florence Wilklow</b>		13e. STREET ADDRESS <b>6200 Lombard ST.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>718-10-6477</b>		17. INFORMANT ADDRESS <b>Annette E. Frey (Niece) same as blk 13e</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4280 IMMEDIATE CAUSE (a) CMT</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Tandice</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>11-14-</b> 19 <b>83</b> , to <b>11-30-</b> 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>11-29-</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>David Cromwell M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11/30/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAVID CROMWELL, M.D.</b>				22e. ADDRESS <b>831 Univ. Blvd. E. Silver Spring, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec 3, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Baltimore Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Francis Gasch's Sons, Funeral Home, Hyattsville, Md.</b>				25. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>DEC 5 1983 John J. Connelley</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										30585	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Evelyn		J.		Garthune	11		7	83	1:16 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		Caucasian		7 28 03		80		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Iowa		USA				Montgomery County				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Rockville		Collingswood Nursing Center		Retired technical Editor							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		20854	
Maryland		Montgomery		Potomac				10615 Great Arbor Drive			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
Ulysses		Angie								Sayre	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		579-42-3708		Mary Lauer same as 13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> 33336 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Progressive dystonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (this hospital) attended the deceased from <u>May</u> , 19 <u>81</u> , to <u>Nov</u> , 19 <u>83</u> , that (we) lost saw the deceased alive on <u>Sept 26</u> , 19 <u>83</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>William H. Silverman MD</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> GHA <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>11/7/83</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>WILLIAM H. SILVERMAN</u>				22e. ADDRESS <u>6111 EXECUTIVE BLVD, ROCKVILLE, MD</u>							
23a. BURIAL, CREMATION, REMOVAL <u>Cremation</u>		23b. DATE <u>11/8/83</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION CITY OR TOWN <u>Suitland, Maryland</u>		STATE <u>Maryland</u>			
24. FUNERAL DIRECTOR NAME <u>Tyson Wheeler Funeral Home, Inc.</u> <u>1331 Rockville Pike Rockville, Md. 20852</u>						25a. DATE REC'D. BY REGISTRAR <u>NOV 10 1983</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Smith</u>			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, 3, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 100-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 2 AND 3 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										30586 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Helena M. Gartrell</b>						2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>Nov. 9 1983</b>		2b. HOUR OF DEATH MIN. <b>7:00 PM</b>			
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12/13/15</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>67 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>Nov. 10 1983</b>		7d. HOUR OF DEATH MIN. <b>1:00 PM</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>					
10. CITY OR TOWN OF DEATH <b>Ft. Det Park</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Wash. Ad. Care Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Unemployed</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md.</b>						13b. COUNTY <b>Montg.</b>		13c. CITY OR TOWN <b>Ft. Det Park</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>FRANK Coran</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Laura Jenkins</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-14-7318</b>		17. INFORMANT ADDRESS <b>George McDonald (son) 15611 Quince Orchard Rd. G'burg</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4291 Acute Myocardial Dis</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>Chronic Myocardial Dis</b> (c) <b>4 yrs</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <b>None</b>											
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>[Signature]</b>		TITLE (SPECIFY) <b>M.D. Dep.</b>		MEDICAL EXAMINER				DATE SIGNED <b>Nov. 10/1983</b>			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11-15-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Poplar Grove Cem.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Gaithersburg, Montg Md.</b>			
24. FUNERAL DIRECTOR NAME <b>George R. Snowden</b>		ADDRESS <b>246 N. Wash. St. Rockville, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1983</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

100-1101-100

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

Handwritten: 100-1101-100



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Louise McWorter Gathgens			2a. DATE OF DEATH MONTH DAY YEAR November 19, 1983			2b. HOUR 2:00A <sub>M</sub>			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Sept. 26, 1894		6. AGE (IN YEARS (LAST BIRTHDAY)) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Chevy Chase Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS (20815) 4621 DeRussey Parkway	
14. FATHER'S NAME FIRST MIDDLE LAST Preston McWorter				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Nolan					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-05-1873		17. INFORMANT ADDRESS David W. Gathgens, same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest.</u> <u>1509</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cancer of esophagus.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>11-16</u> 19 <u>83</u> , to <u>11-19</u> 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>11-16</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Christopher Unger MD</u>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED November 19, 1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Christopher Unger, M.D.				22e. ADDRESS 8218 Wisconsin Avenue, Bethesda, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Nov. 19, 1983		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crem.		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland 20814				25a. DATE REC'D. BY REGISTRAR NOV 21 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Davis</u>			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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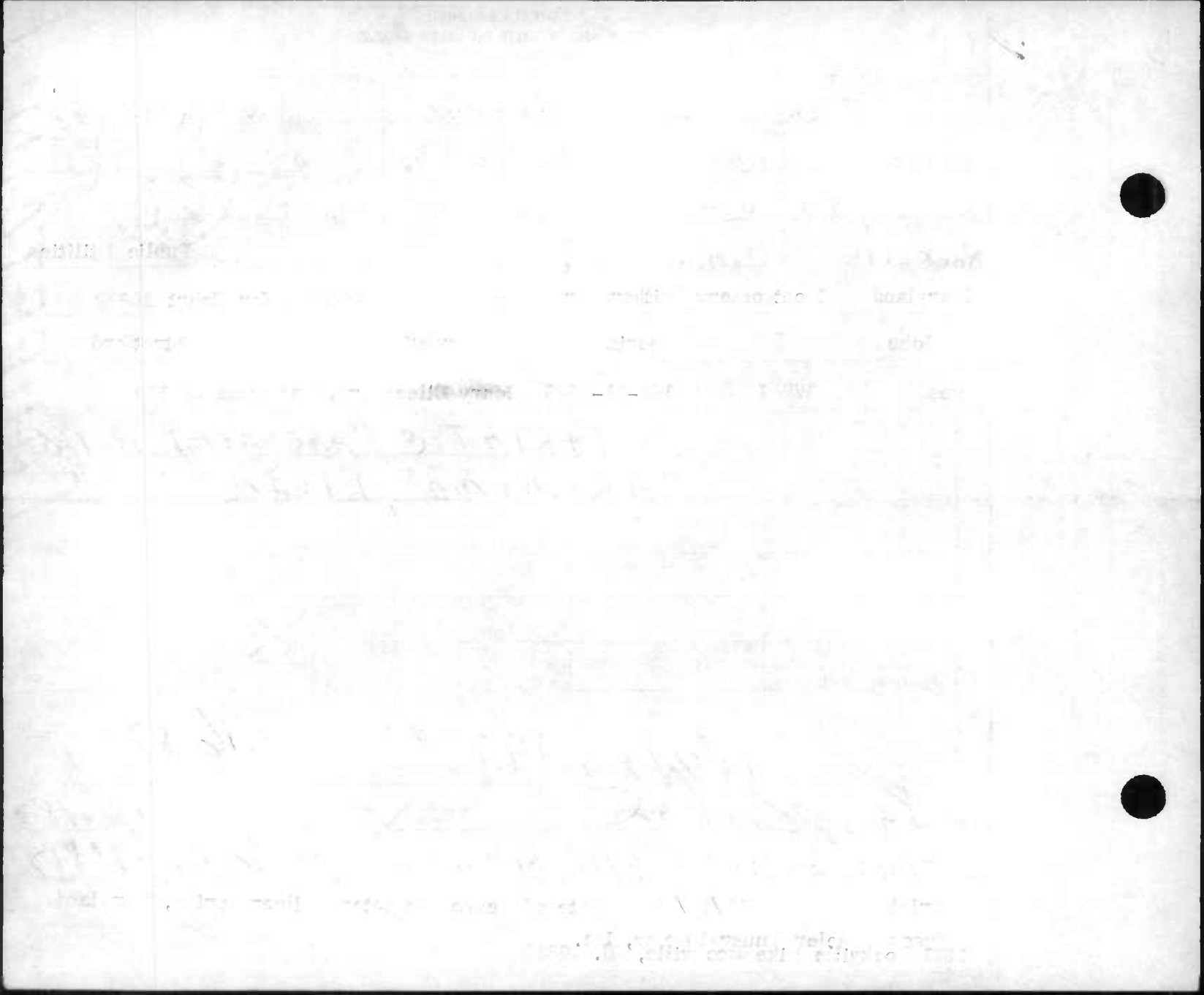
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30588

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Thomas B. Geerin</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>11-16-83</i>		2b. HOUR <i>6 p.m.</i>	
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>05-20-96</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>87</i> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Jersey City, N.J.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.
10. CITY OR TOWN OF DEATH <i>Rockville</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Collingswood</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Salesman</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Public Utilities</i>
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Gaithersburg</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>John Geerin</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Cordelia Stratford</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>yes</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <i>WW I 140-01-2643</i>		17. INFORMANT ADDRESS <i>Mary Eileen Branagan same as 13c</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>METASTATIC CARCINOMA</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>CARCINOMA, LIVER</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>1991</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>WEEKS</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 <i>11/3/83</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>11/16/83</i>		
22a. I certify that (I) (this hospital) attended the deceased from <i>11/3/83</i> to <i>11/16/83</i> , saw the deceased alive on <i>11/4/83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If you did not view the body after death, so state.)						
22b. SIGNATURE <i>Thos G. Ward</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11/16/83</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Thos G. Ward</i>		22e. ADDRESS <i>6116 Robinwood, Bethesda, Md 20817</i>				
23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>		23b. DATE <i>11/19/83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cemetery</i>		23d. LOCATION CITY STATE COUNTY <i>Silver Spring, Maryland</i>
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home, Inc.</i> <i>1331 Rockville Pike Rockville, Md. 20852</i>				25a. DATE REC'D. BY REGISTRAR <i>NOV 21 1983</i>		
				25b. REGISTRAR'S SIGNATURE <i>John J. Smith</i>		



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) George J. Georgis			2a. DATE OF DEATH MONTH DAY YEAR 11 1 83			2b. HOUR 7:30 PM			
3 SEX male		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR 11 03 93		6 AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greece		7b. CITIZEN OF WHAT COUNTRY? Greek/USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Sandy Spring Montgomery MD			
10 CITY OR TOWN OF DEATH Sandy Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Friends House Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK, OR MOST OF WORKING LIFE) Restauranteur		12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. STATE Michigan			13b. COUNTY Westland		13c. CITY OR TOWN Westland		13d. STREET ADDRESS 32929 Hampshire Ave 99999		
14. FATHER'S NAME FIRST MIDDLE LAST Demetrios Georgopoulos			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Panayota Manzuranis						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 377-04-5802		17 INFORMANT 2020 Franwall Ave., Wheaton, Md. Dimitris Georgopoulos (Nephew) 20902				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Cardio respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction = C.H.F. DUE TO, OR AS A CONSEQUENCE OF (c) Aortic Aneurysm APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 2 wks years									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Organic Brain Syndrome									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 12/14/81 to 11/1/83, that (I) (the) last saw the deceased on 10/31/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (list as) (did) (not) view the body after death.									
22b. SIGNATURE C.H. Ligo MD						DEGREE		22c. DATE SIGNED 11/1/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C.H. Ligo MD						22e. ADDRESS 1811 P & Phily Dr., Olney MD 20832			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/4/83		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.		
24 FUNERAL DIRECTOR NAME Hines/Rinaldi 11800 New Hampshire Ave. S.S. Md.						25a. DATE REC'D. BY REGISTRAR NOV 4 1983		25b. REGISTRAR'S SIGNATURE	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
ALVIN "A" GERMAN			NOVEMBER 16 1983			9:44aM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE	CAUCASIAN	JULY 24 1927	56			MONTHS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
TEXAS	UNITED STATES		MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
BETHESDA	NAVAL HOSPITAL		RETIRED NAVY					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
MARYLAND			HARFORD			EDGEWOOD		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
VANN			IDA MAY RIDDINGS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT		
YES			1943-1963			467-26-1989		
						MINNIE VIRGINIA GERMAN		
						EDGEMOND MD 21040		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>METASTATIC CARCINOMA OF BLADDER</u> 1889 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO, OR AS A CONSEQUENCE OF								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>OCT 14</u> , 19 <u>83</u> , to <u>NOV 16</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>NOV 16</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE			DEGREE			22c. DATE SIGNED		
<u>R.W. Hargraves MD</u>						11/16/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
R.W. HARGRAVES, LT, MC, USNR			NAVAL HOSPITAL BETHESDA MD 20814					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial			11-19-83		Dulaney Valley Mem Gardens		Cockeysville Balto. Md.	
24. FUNERAL DIRECTOR NAME			25. DATE REC'D. BY REGISTRAR			25. REGISTRAR'S SIGNATURE		
Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, Maryland 21133			NOV 1 8 1983			<u>John J. Gwinn</u>		

MEDICAL CERTIFICATION

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. The text appears to be organized into paragraphs and possibly includes a table or list structure.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 30591			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>John Charles Gervase</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11-12-83</b>		2b. HOUR <b>5:05p.m.</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 12 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>78</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>	
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Cab Co. Buffalo</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Anthony Gervase</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Josephine Rizzuto</b>		13e. STREET ADDRESS <b>10703 Blossom Lane</b>		20903	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>071-01-0979</b>		17. INFORMANT ADDRESS <b>Rose A. Gervase Wife Same as 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>2500 IMMEDIATE CAUSE (a) CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>coronary artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>diabetes</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Hepatitis chronic obstructive Pulmonary disease</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11-12-83</b> to <b>11-12-83</b> , that (I) (we) last saw the deceased alive on <b>11-12-83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>M Snow MD</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MSNOW MD</b>		22e. ADDRESS <b>9013 FLOWER AVE, SILVER SPRING Md 20901</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 16, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Mont. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 17 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>	
500 University Blvd., W. Silver Spring, Md.							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30592

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Viola D. Gibson			2a. DATE OF DEATH MONTH DAY YEAR Nov -11-83		2b. HOUR 8:00P M
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR March 6, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Gaithersburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7733 Mineral Springs Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY None	
13a. STATE Md	13b. COUNTY Montg.	13c. CITY OR TOWN Gaithersburg	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 7733 Mineral Springs Drive	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Dorsey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Brooks			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-07-6589		17. INFORMANT ADDRESS Mrs Viola Simpson (Daughter) Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal failure</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Gangrene</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 wks 4d 4 wks 4d Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Coronary heart disease</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>April</u> 19 <u>82</u> to <u>Nov 11</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>October 24</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <u>Sidney J. Cohen</u>		DEGREE M.D.		22c. DATE SIGNED 11/12/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sidney J. Cohen, M.D.		22e. ADDRESS 121 Congressional Lane, Rockville, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11-15-83	23c. NAME OF CEMETERY OR CREMATORY Emory Grove Cemetery		23d. LOCATION CITY OR TOWN COUNTY Gaithersburg, Montg. Md.	
24. FUNERAL DIRECTOR NAME George R. Snowden		24b. ADDRESS 246 N. Washington St. Rockville, Md. 20850		25a. DATE REC'D. BY REGISTRAR NOV 17 1983	25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>

STATE OF NEW YORK  
IN SENATE  
JANUARY 1, 1903



RECEIVED  
JAN 1 1903  
STATE OF NEW YORK

FILED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 16b 4/19/84 mth.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 5 9 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Katherine E. Giles			2a. DATE OF DEATH MONTH DAY YEAR November 18, 1983			2b. HOUR 6 A M	
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR June 10, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC	7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7109 Denton Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Gaines Easley			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Evelyn Curlett				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218/38/7317		17. INFORMANT Daughter Cheryl Davenport ADDRESS 8523 Lakinhurst Ln. Springfield, VA			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Probable Cardiac Arrhythmia</i> <i>1749</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Myocardial Ischemic Disease</i> (c) <i>Coronary Artery Disease</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 min.</i> <i>3 1/2 yr</i> <i>20 yr</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>July 15, 1940</i> to <i>18 Nov 1983</i> , that (I) (we) last saw the deceased alive on <i>16 Nov 1983</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Eugene P. Libre</i>					DEGREE <i>M.D.</i>		22c. DATE SIGNED Nov. 18, 1983
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eugene P. Libre, M.D.				22e. ADDRESS 10400 Connecticut Ave. Kensington, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE NOV. 21, 1983		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria, Virginia		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY HOMES, P.A., BETHESDA, MARYLAND				25a. DATE REC'D. BY REGISTRAR NOV 21 1983		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

BP.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 5 9 4

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Catherine Mae Glasgow			2a. DATE OF DEATH MONTH DAY YEAR November 28, 1983		2b. HOUR 9:20A <sub>M</sub>
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR July 26, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Pennsylvania			13b. CITY OR TOWN Blair	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS (16617) 1799 1617 North Tuckahoe St.
14. FATHER'S NAME FIRST MIDDLE LAST William McGinnis		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Sager			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 178-10-8829	17. INFORMANT ADDRESS 100 Hudson Ave. Dorothy Jane Kimmel Altoona, PA		
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4039 IMMEDIATE CAUSE (a) <u>PERIAL INSUFFICIENCY</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>MYO CARDIO SCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARTERIO SCLEROSIS</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (his hospital) attended the deceased from 10/22, 1983, to 11/27, 1983, that (I) (we) lost saw the deceased alive on 11/27, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Thomas E. Dooley, M.D.</u>				22c. DATE SIGNED 11/28/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas E. Dooley, M.D.				22e. ADDRESS 17904 Georgia Ave. Silver Spring, MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Dec. 1, 1983	23c. NAME OF CEMETERY OR CREMATORY Alto Reste Park		23d. LOCATION CITY OR TOWN COUNTY STATE Allegheny Twsp., PA	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland 20814				25. DATE REC'D. BY REGISTRAR DEC 2 1983	
				25. REGISTRAR'S SIGNATURE <u>John J. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE UNIVERSITY OF CHICAGO  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>William M. GOODWIN</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>November 29, 1983</b>		2b. HOUR <b>7:19a M</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>September 8, 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>84</b>		IF UNDER 1 YEAR IF UNDER 24 HRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital, Silver Spring</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Dentist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>			
13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Montgomery</b>		13c. INSIDE CITY LIMITS? <b>YES</b> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>12500 Devan Drive 20910</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Goodwin</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rachael Burton</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes WWI WWII</b>		16b. SOCIAL SECURITY NO. <b>215 38 2778</b>		17. INFORMANT <b>21 Apple Grove Rd. S.S. Md. Devonne Orenge (Daughter)</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrhythmia</b> <b>4149</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary artery disease + Emphysema</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>11/29</b> 19 <b>83</b> to <b>11/29</b> 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>Nov 19 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If two or more did not view the body after death.											
22b. SIGNATURE <b>G. Cushner</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11/29/83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G. Cushner</b>				22e. ADDRESS <b>11161 New Hampshire Ave Silver Spring Md. 20904</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/2/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington, Va.</b>					
24. FUNERAL DIRECTOR <b>Hines/Rinaldi</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 1 1983</b>				25b. REGISTRAR'S SIGNATURE <b>Joan J. Carver</b>			
25c. ADDRESS <b>11800 New Hampshire Ave.</b>											

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Arlington Cemetery Arlington, Va.

Washington Ave. S.W.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>James Clifford Gorman</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>November 29, '83</b>	
3. SEX <b>Male</b>					2b. HOUR <b>4:07 PM</b>	
4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 14, 1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Tennessee</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD.</b>		
12a. USUAL OCCUPATION Ret. (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Systems Analysis</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>US Government</b>				
13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Davidsonville</b>		13c. STREET ADDRESS <b>700 Petersburg Road 21035</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Gaston Gorman</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Letitia Long</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>413-05-1497</b>		17. INFORMANT ADDRESS <b>Mrs. Dorothy Gorman 700 Petersburg Road Davidsonville, MD 21035</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>trauma pneumothorax</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>metastatic lung cancer</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE		
22a. I certify that (1) this hospital attended the deceased from <b>May 81</b> to <b>Nov 29 83</b> , that (1) (we) last saw the deceased alive on <b>11/29 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did; (and) not view the body after death.						
22b. SIGNATURE <b>D J. HAIDAK MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/30/83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D J. HAIDAK MD</b>		22e. ADDRESS <b>6005 Belvedere Rd Hyattsville MD</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec 2, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lakemont Mem. Gardens</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Davidsonville, Anne Arundel, MD</b>						
24. FUNERAL DIRECTOR NAME <b>Keith H. Waters</b> <b>Beall Funeral Home Bowie, Maryland 20715</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 2 1983</b>				
		25b. REGISTRAR'S SIGNATURE <b>San J. Carver</b>				

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>LINUS FRANCIS GREGORY GOYETTE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 2 1983</b>		2b. HOUR <b>3:55 P.M.</b>
3. SEX <b>MALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 10 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MASS</b>	7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b> <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Accountant</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Federal Government</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>MONTGOMERY</b>	13c. CITY OR TOWN <b>BETHESDA</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>FRANCIS AMOS GOYETTE</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>KATRINA WINIFRED HACKETT</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>1941-1967</b>		17. INFORMANT (Nephew) ADDRESS <b>2902 Gold Mine Rd. Brookville, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <b>SQUAMOUS CELL CA OF HEAD AND NECK</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ 1734 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 1</b> , 19 <b>83</b> , to <b>NOVEMBER 2</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>NOVEMBER 2</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>J.P. Asher</i>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>3 Nov 83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JEANNE P. ASHER, LT, MC, USNR</b>		22e. ADDRESS <b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Nov. 7, 1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland</b>			25a. DATE REC'D. BY REGISTRAR <b>NOV 7 1983</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30598

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>EARL K GRABLE</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>3</b> YEAR <b>83</b>		2b. HOUR <b>11:50 A</b>
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH <b>Sept</b> DAY <b>29</b> YEAR <b>1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Indiana</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Self-employed</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Eaton</b>		13c. CITY OR TOWN <b>Dimondale</b>	
14. FATHER'S NAME FIRST <b>Marion</b> MIDDLE <b>Grable</b> LAST <b>Finnetta</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Finnetta</b> MIDDLE <b>Paulus</b> LAST <b>Paulus</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>	
16b. SOCIAL SECURITY NO. <b>369 014853</b>		17. INFORMANT <b>Irene Grable - see #13 above</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4413</b> IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF <b>ABDOMINAL SEPSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>RUPTURED ABDOMINAL AORTIC ANEURYSM</b> DUE TO, OR AS A CONSEQUENCE OF <b>27 Days</b> (c) <b>27 Days</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>MYOCARDIAL INFARCTION, ACUTE CHOLECYSTITIS, DUODENAL FISTULA, ACUTE RENAL FAILURE</b>					
19a. DATE OF OPERATION <b>10/21/83</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ruptured Abdominal Aneurysm</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>19</b>	
21e. LOCATION STREET		CITY OR TOWN		COUNTY	
STATE		22a. I certify that (this hospital) attended the deceased from <b>10-7</b> , 19 <b>83</b> , to <b>11-3</b> , 19 <b>83</b> , that (we) lost saw the deceased alive on <b>11-3</b> , 19 <b>83</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.			
22b. SIGNATURE <b>Cheyney</b>		DEGREE		22c. DATE SIGNED <b>11-3-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CHEYNEY</b>		22e. ADDRESS <b>Holy Cross Hospital, S.S. Mo.</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-7-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dimondale Cemetery</b>	
23d. LOCATION CITY OR TOWN <b>Windsor Township</b>		COUNTY <b>Maryland</b>		STATE <b>Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>IVES &amp; PEARSONS</b>		ADDRESS <b>Arlington, VA 22201</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 7 1983</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

[illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30599

1 - FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>ISIDORE GREENWALD</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 11 1983</b>	
3 SEX <b>Male</b>		2b. HOUR MIN. <b>5:10A</b>	
4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>March 14, 1893</b>	
6 AGE (IN YEARS LAST BIRTHDAY) <b>90</b>		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Hungary</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Wheaton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>RANDOLPH HILLS NURSING HOME</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Merchant</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Dry Goods</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>	
13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>507 Lamberton Drive</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>Emanuel Greenwald</b>	
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Betty Klein</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	
16b. SOCIAL SECURITY NO. <b>080-28-9178</b>		17. INFORMANT ADDRESS <b>Rhoda Lawrence</b> <b>Same as No. 13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4140</b> IMMEDIATE CAUSE (a) <b>generalized vasculopathy</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>arteriosclerotic heart disease, diabetes</b>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/9 83</b> to <b>11/11 83</b> , that (I) (we) lost saw the deceased alive on <b>11/9 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>D. V. ROSENDAUM</b>		22c. DATE SIGNED <b>11/11/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D. V. ROSENDAUM</b>		22e. ADDRESS <b>3720 FARRAGUT AVE KENSINGTON, MD 20895</b>	
23a. BURIAL, CREMATION, REMOVAL (RECEIVED) <b>Burial</b>		23b. DATE <b>11/13/1983</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Beth El Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Paramus, New Jersey</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Donald M. Stein Hebrew Memorial F. H. 232 Carroll Street, N. W. Washington, D. C.</b>		24a. DATE REC'D. BY REGISTRAR <b>NOV 14 1983</b>	
24b. REGISTRAR'S SIGNATURE <b>John J. Ganiel</b>			

Handwritten: *Handwritten signature* 23 4 1 VON.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30600

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>REBECCA S. GREENWELL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 25, 1983</b>		2b. HOUR <b>10 A M</b>
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>May 1, 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>80</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kentucky</b>	7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>	
10. CITY OR TOWN OF DEATH <b>Bethesda, MD</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher for Deaf Education</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Virginia</b>		13b. COUNTY <b>Prin. Wm.</b>	13c. CITY OR TOWN <b>Gainesville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Siler</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nannie McCarley</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>230 48 5191</b>		17. INFORMANT ADDRESS <b>James Siler Nephew Same as item 13</b>	

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>5570 IMMEDIATE CAUSE (a) probable perforated viscous</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>high infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>probable mesenteric infarction</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>severe congestive heart failure. Mitral stenosis. Emaciation</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11-25-83</b> to <b>11-25-83</b> , that (I) (we) last saw the deceased alive on <b>11-25-83</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>H. Bahar</b>		DEGREE		22c. DATE SIGNED <b>11-25-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HADI BAHAR</b>		22e. ADDRESS <b>8218 Wisconsin Ave. Bethesda, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 29, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lancaster Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Lancaster Kentucky</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Lauer</b>	





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30601

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>DOROTHY H GRIER</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>18</b> YEAR <b>83</b>		2b. HOUR <b>10 22 AM</b>
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH <b>06</b> DAY <b>14</b> YEAR <b>20</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2833 LEMAR STREET</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD.</b>	
13a. STATE <b>MD</b>			13b. COUNTY <b>MONT.</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>
14. FATHER'S NAME FIRST <b>EARL</b> MIDDLE <b>S.</b> LAST <b>HAISLIP</b>			15. MOTHER'S MAIDEN NAME FIRST <b>DOROTHY</b> MIDDLE <b>HILL</b> LAST <b>HILL</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>220-46-7070</b>		17. INFORMANT ADDRESS <b>RALPH H GRIER, 2833 LEMAR STREET</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO, OR AS A CONSEQUENCE OF (b) <b>METASTATIC BREAST CARCINOMA</b>	<b>5 YEARS</b>
	DUE TO, OR AS A CONSEQUENCE OF (c)	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <b>11/1</b> , 19 <b>83</b> , to <b>11/18</b> , 19 <b>83</b> , that (1) (a) lost saw the deceased alive on <b>11/1</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Alan Jay Diamond</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/19/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALAN JAY DIAMOND</b>		22e. ADDRESS <b>1106 SPRING ST, SILVER SPRING, MD</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Nov. 21, 1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>	23d. LOCATION CITY OR TOWN <b>Washington</b> COUNTY <b>D.C.</b> STATE <b>D.C.</b>
24. FUNERAL DIRECTOR NAME <b>Takoma Funeral Home, 2400 N. 25th St, Takoma Park, MD</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 22 1983</b>	
25b. REGISTRAR'S SIGNATURE <b>Chas. J. Carter</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30602

1. FOR  
STATE  
REGISTRAR

GRIFFIN MRS EARNESTINE

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>GRIFFIN MRS EARNESTINE P</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-19-83</b>			2b. HOUR <b>2:02 A M</b>				
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 13 13</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>70</b>		IF UNDER 1 YEAR IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>U.S.A. S.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.				
10. CITY OR TOWN OF DEATH <b>TAKOMA PK</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON ADVENTIST HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NONE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>TAKOMA PK</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>7600 Carroll Av TP MD</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Home Pickett</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah Latta</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>577 38 6363</b>		17. INFORMANT ADDRESS <b>Tijuana Griffin 8710-Reading Rd. Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b> <b>4/40</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ATHEROSCLEROTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>5 YEARS</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 YEARS</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>RHEUMATOID ARTHRITIS</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) this hospital attended the deceased from <b>OCT 09</b> , 19 <b>83</b> , to <b>NOV</b> , 19 <b>83</b> , that (2) we last saw the deceased alive on <b>OCT</b> , 19 <b>83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did/did not) view the body after death.										
22b. SIGNATURE <b>Robert L. Rosenberg</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/20/83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT L. ROSENBERG, MD</b>			22e. ADDRESS <b>1131 UNIVERSITY BLVD W, SILVER SPRING, MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>23/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Mem. Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, P.G. Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Washington Fun. Chapel</b>			ADDRESS <b>3821-14th St NW, Wash DC</b>			25a. DATE REC'D. BY REGISTRAR <b>NOV 22 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Loefer</b>		

BP





M

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 6 0 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ALMA B GRIM</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11/6/83</b>			2b. HOUR <b>5:50 PM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 15 94</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>S.S.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Va.</b>				13b. COUNTY <b>Richmond</b>		13c. CITY OR TOWN <b>Richmond</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Franklin W. Berry</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Price</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>226 92 1790</b>		17. INFORMANT <b>312 Apple Grove Rd. S.S. Md.</b> <b>Phyliss Viccellio (Daughter)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4100 IMMEDIATE CAUSE (a) Myocardial Infarct, Acute</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arterio-sclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cardiogenic Shock</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b> <b>15 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Anemia</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>10-1-83</b> , 19____, to <b>11-6-83</b> , 19____, that (I) (we) last saw the deceased alive on <b>11-6-83</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>George B Patrick MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>11-6-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>George B PATRICK JMD</b>				22e. ADDRESS <b>9831 Coleville Rd Silver Spring, Md 20910</b>			
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>11/ 9 /83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Liberty Christian Church Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Richmond, Va.</b>	
24. FUNERAL DIRECTOR <b>Hines/Rinaldi</b>				11800 New Hampshire Ave. S		25. DATE REC'D. BY REGISTRAR <b>NOV 7. 1983</b>	
				25. REGISTRAR'S SIGNATURE <b>John J. Conner</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

April 1961

1961

*[Faint, mostly illegible handwritten text follows, appearing to be a list or journal entry. Some words like "April", "1961", and "1961" are visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Nathaniel Grosman</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>11-11-83</i>			2b. HOUR <i>7:50 PM</i>	
3 SEX <i>Male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>January 27, 1904</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>79</i>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Connecticut</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10 CITY OR TOWN OF DEATH <i>Wheaton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <i>RANDOLPH HILLS NURSING HOME</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Attorney</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Govt.</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN <i>Maryland Montgomery Catonsville</i>				13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS <i>10010 Stedwick Road 20859</i>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>Jacob Grosman</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE <i>Ethel Frankel</i>					
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>		16b. SOCIAL SECURITY NO <i>579-01-1660</i>		17 INFORMANT ADDRESS <i>Lorrie S. Grosman Same as No. 13</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Renal Failure</i> <i>3109</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Dehydration, Anemia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Dysrhythmic Brain Syndrome</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>Prostatic Hypertrophy - Urine Retention</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>DR. UNIVERSITY</i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>1982</i> to <i>PRESENT</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>11-6</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Douglas R. Shumaker MD</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>11/11/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DOUGLAS R. SHUMAKER, MD</i>		22e. ADDRESS <i>615 W. MONTGOMERY AVE ROCKVILLE, MD 20850</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>11/13/1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mount Lebanon Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Adelphi, Pr. Geo., Maryland</i>	
24 FUNERAL DIRECTOR <i>Donald M. Stein Hebrew Memorial F.H.</i>				25a. DATE REC'D. BY REGISTRAR <i>NOV 16 1983</i>			
25b. REGISTRAR'S NAME <i>John J. Gault</i>				25c. REGISTRAR'S ADDRESS <i>232 Carroll Street, N. W. Washington, D. C.</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30605

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Edward D. Hackett</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>3</b> YEAR <b>83</b>			2b. HOUR <b>5:30</b> AM					
3. SEX <b>M</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>June</b> DAY <b>21</b> YEAR <b>1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Chevy Chase Nursing Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Electrician</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>D.C. Government</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Anne Arundel</b> 13c. CITY OR TOWN <b>Shady Side</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1522 Columbia Drive 20764</b>					
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>F.</b> LAST <b>Hackett</b>				15. MOTHER'S MAIDEN NAME MIDDLE <b>Mollie</b> LAST <b>Myers</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>344-22-8571</b>		17. INFORMANT <b>Washington, D. C. 200 15</b> <b>John R. McGuire, nephew, 5743 26th St. N.W.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4140</b> IMMEDIATE CAUSE (a) <b>Cardiac respiratory arrest</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Chronic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cerebral Vascular thrombosis - left hemiplegia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)							
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (1) <b>Dr. Blaine Fitzgerald</b> attended the deceased from <b>July 2</b> 19 <b>83</b> , to <b>November 3</b> 19 <b>83</b> , that (1) <b>last</b> saw the deceased alive on <b>Nov 1</b> 19 <b>83</b> , and that in (my) <b>own</b> opinion death occurred on the date and hour and from the causes stated above, (2) <b>I</b> (did) <b>not</b> view the body after death.											
22b. SIGNATURE <b>Blaine Fitzgerald</b>				22c. DATE SIGNED <b>11/3/83</b>				22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. Blaine Fitzgerald, M.D.</b>				22f. ADDRESS <b>8218 Wisconsin Ave., Bethesda, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. , 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek</b>		23d. LOCATION CITY OR TOWN <b>Washington, D. C.</b> COUNTY <b></b> STATE <b></b>					
24. FUNERAL DIRECTOR NAME <b>McGuire Funeral Service, Inc.</b>				7400 Georgia Ave. NW Washington, D.C.				DATE REC'D. BY REGISTRAR <b>NOV 16 1983</b> REGISTRAR'S SIGNATURE <b>John J. Gans</b>			

MEDICAL CERTIFICATION

Handwritten: *Handwritten text, possibly a signature or date.*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Per birth Cert.mtb

1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ADOLPHUS DONNELL HALL			2a. DATE KNOWN OF DEATH ESTIMATED 11 11 19 83			2b. HOUR M		
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Sept. 25 71	6. AGE (IN YEARS) (LAST BIRTHDAY) 12 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD 11 11 19 83	2d. HOUR 8:40 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE ADDRESS) Holy Cross Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STUDENT		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY P.G.		13c. CITY OR TOWN Suitland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Adolphus Hall Jr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Evelyn Hunt		13e. STREET ADDRESS 4701 Medora Dr. 20746				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Evelyn Hall (Mother) Same as 13e				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 3439 IMMEDIATE CAUSE (a) Cerebral palsy with complications Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE Ann M. Dixon		TITLE (SPECIFY) Assistant		M.D. MEDICAL EXAMINER		DATE SIGNED 11-13-83		
EXAMINER'S NAME (TYPE OR PRINT)		Ann M. Dixon, M.D.		ADDRESS		111 Penn St., Balto., Md. 21201		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 15 Nov. 83		23c. NAME OF CEMETERY OR CREMATORY Meherrin Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Meherrin, VA.		
24. FUNERAL DIRECTOR NAME FRAZIER'S Funeral Home		ADDRESS 389 R.I. Ave. NW Washington, D.C.		25a. DATE REC'D. BY REGISTRAR NOV 16 1983		25b. REGISTRAR'S SIGNATURE John J. Connel		



EX-100





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30607

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ALMA KNIGHTON HALL			2a. DATE OF DEATH MONTH DAY YEAR 11/29/83		2b. HOUR 3:10 P.M.			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR NOV. 26, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 86 YES MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sharon Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY Acct.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 21239			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Thomas Knighton			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Liberty - Hall					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 212-03-4794-A		17. INFORMANT ADDRESS Sue Kraus 3538 Fitzhugh Lane Silver Spring, Md.				
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Failure</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Renal Disease</u> years PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Oxymore Blau Syndrome</u> APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH <u>3 days</u> <u>2 wks</u> <u>years</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital attended the deceased from <u>12/21</u> <u>83</u> to <u>11/29</u> <u>83</u> , that (1) (we) last saw the deceased alive on <u>11/28</u> <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (live) (died) (died) view the body after death.								
22b. SIGNATURE <u>[Signature]</u>		22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <u>11/29/83</u>				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>E. H. H. [Signature]</u>		22f. ADDRESS <u>1811 P. Philip St., Olney Md 20832</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 1, 1983		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore Md.		
24. FUNERAL DIRECTOR FRANCIS H. BARBER LAYTONSVILLE, MD. 20879				25a. DATE REC'D. BY REGISTRAR DEC 5 1983		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

MEDICAL CERTIFICATION

BP

*[Faint handwritten notes and bleed-through from the reverse side are visible across the page.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DAISY HALL			2a. DATE OF DEATH MONTH DAY YEAR NOV 1 1983		2b. HOUR 0018 M
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Mar, 9, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.			13b. COUNTY Montg	13c. CITY OR TOWN Rockville	
14. FATHER'S NAME FIRST MIDDLE LAST Luther Williams			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sadie Russell		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS William Hall (husband) Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9120 <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aspiration</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>immud</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immud</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Ilio-colonic-vestical fistula w/ Diverticulitis - resection + colostomy</u> 10/19/83					
19a. DATE OF OPERATION 10/19/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Fistula		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/30/83</u> 19 <u>83</u> , to <u>10/1/83</u> 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>10/31/83</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <u>Robert Millman MD</u>		DEGREE MD		22c. DATE SIGNED 11/1/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Millman, MD		22e. ADDRESS 15 E Deer Park Dr Gaithersburg MD 20877			
23a. BURIAL, CREMATION, REMOVAL (CHECK) Burial		23b. DATE 11-5-83		23c. NAME OF CEMETERY OR CREMATORY Lincoln Park Cem.	
23d. LOCATION CITY OR TOWN COUNTY Rockville Montg. Md.		24. FUNERAL DIRECTOR NAME George R. Snowden			
24b. ADDRESS 246 N. WASH. ST. Rockville Md		25a. DATE REC'D. BY REGISTRAR NOV 04 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Smith</u>	

BP \_\_\_\_\_



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*[Faint, illegible handwritten text on lined paper]*

*[Faint, illegible handwritten text at the bottom of the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROY ALSTON HANNA			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 29, 1983		2b. HOUR 12:40 <sup>a</sup> <sub>M</sub>
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR MAY 16, 1925		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY, MD.		
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CLINICAL CENTER (NIH)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self employed		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) W. STATE VIRGINIA RICHMOND		13b. CITY OR TOWN RICHWOOD	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 3 RD. STREET 26261	
14. FATHER'S NAME FIRST MIDDLE LAST Archie Hanna		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vernice Lewis			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-22-4259	17. INFORMANT ADDRESS MRS. ELAINE HANNA (WIFE) SAME AS ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic encephalopathy 1579 DUE TO, OR AS A CONSEQUENCE OF (b) Metastases pancreatic cancer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JULY 31, 1983, to NOV. 29, 1983, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on NOV. 29, 1983, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (I) (we) (did) (do not) view the body after death.					
22b. SIGNATURE Walter J Urba MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 11/29/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER URBA		22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MD 20205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) removal	23b. DATE 11-30-83	23c. NAME OF CEMETERY OR CREMATORY Simon & Coleman F/H		23d. LOCATION CITY OR TOWN COUNTY STATE Richwood, West Virginia	
24. FUNERAL DIRECTOR NAME ADDRESS MARSHALL'S FUNERAL HOME 4217 9th Street NW: Washington, D.C.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 5 1983 John J. Connel			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 18, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

BP

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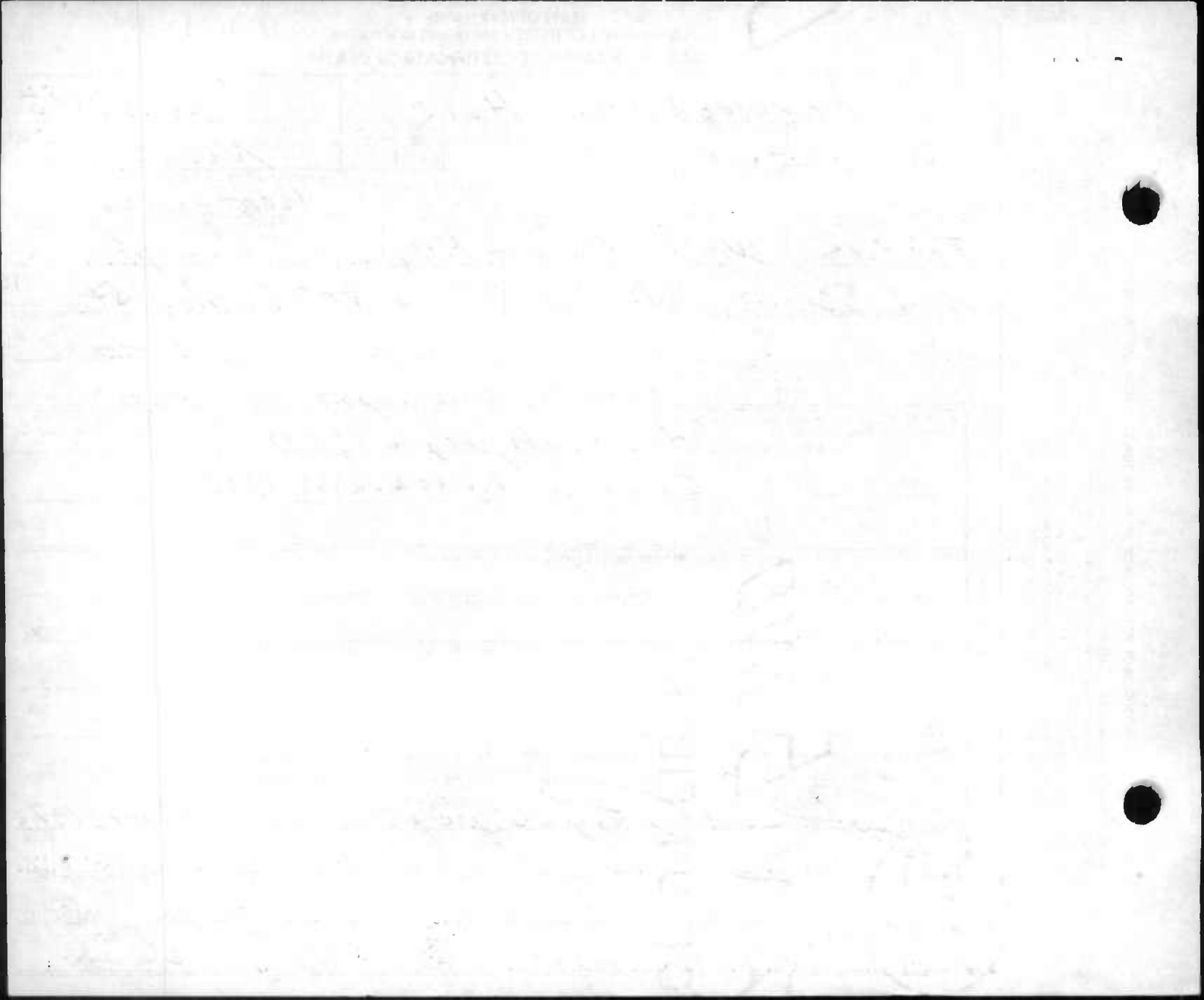
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30610

FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Kerwood William Hanson</i>				2a. DATE KNOWN OF DEATH MONTH DAY YEAR <i>Nov. 22 1983</i>				2b. HOUR OF DEATH MIN. SEC. <i>5:40 P</i>			
3. SEX <i>M</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>11. 99 84</i>	6. AGE (IN YEARS) YRS. <i>84</i>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>Nov. 22 1983</i>	2d. HOUR OF DEATH MIN. SEC. <i>5:40 P</i>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Nebraska</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.					
10. CITY OR TOWN OF DEATH <i>Tak Park</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN WHICH FACILITY, GIVE STREET ADDRESS) <i>Wash. Advent Hosp.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Carpenter Foreman</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>G.S.A.</i>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS <i>407 Easley St.</i>		20910	
13a. STATE <i>MD</i>	13b. COUNTY <i>Mont.</i>	13c. CITY OR TOWN <i>Bethesda</i>	14. FATHER'S NAME FIRST MIDDLE LAST <i>John M. Hanson</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Wilhemina Johanson</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>WWI</i>		17. INFORMANT <i>Gladys A. Hanson</i>		ADDRESS <i>Wife Same as 9</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <i>4291 Acute Myocardial Inf.</i> IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF <i>Chronic Myocardial Inf.</i> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>None</i>											
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>John S. Rogers</i>				TITLE (SPECIFY) <i>Medical Examiner</i>				DATE SIGNED <i>Nov 22 1983</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>John S. Rogers, M.D.</i>				ADDRESS <i>1919 Seminary Road Silver Spring, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Nov. 26, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Brentwood Pr. Geo. Maryland</i>					
24. FUNERAL DIRECTOR NAME <i>Francis J. Collins</i>				25a. DATE REC'D. BY REGISTRAR <i>DEC 2 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John S. Collins</i>					
500 University Blvd., W. Silver Spring, Md.											





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 6 1 1

1. FOR STATE REGISTRAR			2a. DATE OF DEATH			2b. HOUR		
FIRST	MIDDLE	LAST	MONTH	DAY	YEAR	DAY	YEAR	MIN
1. DECEASED NAME (TYPE OR PRINT) Nina B. Harlow			November 17, 1983			2:10P M		
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH May 16, 1925		6. AGE (IN YEARS LAST BIRTHDAY) 58		8. IF UNDER 1 YEAR MONTHS DAYS		9. IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD		
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) #7 Grove Point Court		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Mont. Co. School Board		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME Clarence Lee Bradfield			15. MOTHER'S MAIDEN NAME Nina Myers			13e. STREET ADDRESS #7 Grove Point Court		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 228 22 5053		17. INFORMANT (Husband) ADDRESS Thomas L. Harlow #7 Grove Pt. Ct. Rockville, MD			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> <u>1919</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>MALIGNANT BRAIN TUMOR</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION <u>August 1983</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>BRAIN TUMOR &amp; HEMORRHOE</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>83</u> to <u>Nov 17</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>Nov. 1</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Bernard Stopak MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Nov 17, 1983		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bernard Stopak MD				22e. ADDRESS Maryland 20815 5530 Wisconsin Avenue, Chevy Chase				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 21, 1983		23c. NAME OF CEMETERY OR CREMATORY Monticello Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Charlottesville, VA.		
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY P.A., ROCKVILLE, MARYLAND				25a. DATE RECD. BY REGISTRAR NOV 21 1983		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If a delay is expected, the certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Perle M. Hartzell</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-24-83</b>			2b. HOUR <b>5:45</b> M	
3. SEX <b>Female</b>		4. RACE <b>White.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7-24-86</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>97</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>IOWA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON ADVENTIST HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>MONT.</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>CHRISTIAN TEUSCHER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY MAGDALENE BLAVER</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>485-26-3903</b>		17. INFORMANT <b>Janet Pond, ( Daughter )</b>			
				100 Sunnyside Rd S.S. Md.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Massive CVA**  
**4360**  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  
(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF  
(c) \_\_\_\_\_

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from **4-10**, 19 **83**, to **11-24**, 19 **83**, that (we) last saw the deceased alive on **11-23-83**, 19 **83**, and that in **my** (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)

22b. SIGNATURE <b>Charles Franklin Jr</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-24-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles Franklin Jr</b>		22e. ADDRESS <b>11120 N.H. Ave Silver Spring Md 20904</b>					

23a. BURIAL (CREMATION) REMOVAL <b>Cremation</b>		23b. DATE <b>11/25/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood, P. G., Md.</b>	
24a. FUNERAL DIRECTOR <b>Takoma Funeral Home, Inc</b>		24b. ADDRESS <b>254 Carroll St. N. W. D.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will have to sign this certificate.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 6 1 3

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>William Campbell Hasting</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-11-83</b>		2b. HOUR <b>5:58 P.M.</b>	
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>6 18 02</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West VA.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.		
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASH ADVENTIST Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FOREMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>MD</b>		13c. CITY OR TOWN <b>New Carrollton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>George (NA) Hastings</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maggie (NA) Gray</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>228-129645</b>		17. INFORMANT <b>Richard J. Yeck</b> (SAME AS #13)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>mitral regurgitation</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>emphysema, atherosclerosis</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>11/11</b> 19 <b>83</b> to <b>11/11</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>11/11</b> 19 <b>83</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Dr. H. H. H. H.</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/12/83</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>14 Nov 83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood PG. MD</b>
24. FUNERAL DIRECTOR NAME <b>Hales Lenham FHL</b>		ADDRESS <b>9013 Annapolis Rd</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 17 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Gough</b>

BP

William

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William (17) and (18)

George (17) and (18)

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>JANE D. HEBBERT</b>		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>Nov 4 1983</b>		2b. HOUR OF DEATH <b>7:30 P.M.</b>
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Nov 28 1934</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>48 YRS.</b>	7. DATE PRONOUNCED DEAD <b>Nov 4 1983</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mathematician</b>
13a. STATE <b>MD</b>		13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Silver Spring</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Darrell Saunders, Jr.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marion Chewing</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>N/A</b>		16b. SOCIAL SECURITY NO. <b>229-40-7139</b>		17. INFORMANT ADDRESS <b>R. Scott Hebbert-husband- (same as 13e)</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sudden Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: <b>Cirrhosis of Liver</b> DUE TO, OR AS A CONSEQUENCE OF <b>Alcohol</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Yrs.</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) <b>None</b>				
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion				
ACTUAL SIGNATURE <b>John S. Rogers</b>		TITLE (SPECIFY) <b>DME</b>		DATE SIGNED <b>Nov 5 1983</b>
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, DME</b>		ADDRESS <b>1919 Seminary Road, Silver Spring, Md</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>11-8-1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Burtonsville Montgomery Md.</b>
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi Funeral Home</b>		ADDRESS <b>11800 N.H. Ave., Silver Spring, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 7 1983</b>

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. OBTAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 4 AND 5 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
20M 4/82

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>H200 H Leslie Hecht</b>							2a. DATE KNOWN OF DEATH MATED <b>11/20/83</b>		2b. HOUR <b>PM</b>		
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH <b>11</b> DAY <b>25</b> YEAR <b>1953</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>30</b> YRS.	IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.	IF UNDER 24 HRS. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.	7c. DATE PRONOUNCED DEAD <b>11/29/83</b>	2d. HOUR <b>11:50</b>		2e. AM <b>PM</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Illinois</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>					
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>17144 Old Baltimore Rd</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sales Auto</b>		12b. KIND OF BUSINESS <b>Lustone Dotson</b>			
13a. STATE <b>MD</b>							13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Olney</b>		
14. FATHER'S NAME FIRST <b>Louis</b> MIDDLE <b>Hecht</b> LAST <b>Hecht</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Ida</b> MIDDLE <b>Brueske</b> LAST <b>Brueske</b>				16. ADDRESS <b>105 Delford Ave. S.S.Md.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>487 328990</b>		17. INFORMANT <b>Jean A. Hecht (Wife)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gangshot wound of head</b> DUE TO, OR AS A CONSEQUENCE OF <b>9554</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Shot self</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>		21f. LOCATION STREET <b>Old Baltimore Rd</b> CITY OR TOWN <b>Olney</b> COUNTY <b>Montgomery</b> STATE <b>MD</b>					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>John Rogers</b>				TITLE (SPECIFY) <b>Dep</b>				DATE <b>11/29/83</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>John Rogers.M.D.</b>				ADDRESS <b>1919 Seminary Rd. S.S.Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/2/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Cemetery</b>				23d. LOCATION CITY OR TOWN <b>Arlington, Va.</b> COUNTY <b>VA</b> STATE <b>VA</b>			
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi</b> ADDRESS <b>11800 New Hampshire Ave. S.S.Md</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 1 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Grief</b>			

*[Faint, illegible handwriting covering the page]*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Virginia M. Heilmann</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>11 / 83</i>		2b. HOUR <i>659 PM</i>		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>8 10 13</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <i>70</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY</i> MD.	
10. CITY OR TOWN OF DEATH <i>SILVERSPRING</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE <i>Md.</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Snyder</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Elizabeth Barret</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>			
16b. SOCIAL SECURITY NO. <i>215-07-8194</i>		17. INFORMANT ADDRESS <i>Burke, Va. 22015</i> <i>Mr. Joseph J. Heilmann 6300 Skinner Dr.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <i>4860</i> IMMEDIATE CAUSE (a) <i>LEFT LOWER LOBE PNEUMONIA</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 DAYS</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>CHRONIC OBSTRUCTIVE LUNG DISEASE ATRIAL FIBRILLATION</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>OCT 29, 1981</i> , to <i>Nov 1, 1983</i> , that (I) (we) last saw the deceased alive on <i>11/1, 1983</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.							
22b. SIGNATURE <i>Martin C. Shargel</i>		DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11/2/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MARTIN C. SHARGEL</i>		22e. ADDRESS <i>3720 FARRAGUT AVE KENSINGTON, MD-20895</i>					
23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>		23b. DATE <i>Nov. 4, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Most Holy Redeemer</i>		23d. LOCATION <i>Baltimore</i> COUNTY <i>Md.</i> STATE	
24. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc. Baltimore, Maryland</i>				25a. DATE REC'D. BY REGISTRAR <i>NOV 3 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy requested.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) NANCY WALKER HEMPTON				2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 13 1983	
2b. HOUR 1:21 P.M.					
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 12 1923	
6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ILLINOIS		10. CITIZEN OF WHAT COUNTRY? UNITED STATES		11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
12. CITY OR TOWN OF DEATH BETHESDA		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		14. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE MARYLAND		15b. COUNTY MONTGOMERY		15c. CITY OR TOWN ROCKVILLE	
16. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		17. STREET ADDRESS 1380 KIMBLEWICK ROAD 20854			
18. FATHER'S NAME FIRST MIDDLE LAST FREDERICK WILEY WALKER		19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARION CASTNER			
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO None		21. SOCIAL SECURITY NO. 395-20-3153		22. INFORMANT ADDRESS GORDON F. HEMPTON, 1380 KIMBLEWICK ROAD, ROCKVILLE, MD 20854	
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) <u>ADENOCARCINOMA OF LUNG</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
24. DATE OF OPERATION		25. CONDITION FOR WHICH OPERATION WAS PERFORMED		26. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
28. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
31. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		32. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		33. LOCATION STREET CITY OR TOWN COUNTY STATE	
34. I certify that (I) (this hospital) attended the deceased from <u>OCTOBER 17</u> , 19 <u>83</u> , to <u>NOVEMBER 13</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>NOVEMBER 13</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) examine the body after death.					
35. SIGNATURE <i>Ronald P. Sen</i>		36. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		37. DATE SIGNED 14 NOV 1983	
38. PHYSICIAN'S NAME (TYPE OR PRINT) RONALD P. SEN, LT, MC, USN		39. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814			
40. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		41. DATE 11-15-1983		42. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	
43. LOCATION CITY OR TOWN COUNTY STATE Suitland, Prince Geo, Md		44. DATE REC'D. BY REGISTRAR NOV 17 1983			
45. REGISTRAR'S SIGNATURE <i>John J. Connel</i>					



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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. FOR STATE REGISTRAR					
1. DECEASED NAME FIRST MIDDLE LAST <i>Margaret B. Henderson</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>12 Nov 83</i>	
3. SEX <i>female</i>		4. RACE <i>Cauc.</i>		2b. HOUR <i>10<sup>50</sup> P.M.</i>	
5. DATE OF BIRTH MONTH DAY YEAR <i>10 5 06</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>77</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Va.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Bethesda Health Care CTR</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Domestic Work</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Self Employ</i>		13a. STREET ADDRESS <i>1910 35th ST. NW</i>	
13a. STATE <i>Wash. D.C.</i>		13b. COUNTY <i>WASH. DC</i>		13c. CITY OR TOWN <i>WASH. DC</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Steve Henderson</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MARtha Cummings</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>	
16b. SOCIAL SECURITY NO. <i>578-10-0623</i>		17. INFORMANT <i>Doris Watson</i>		ADDRESS <i>3073 Benning Rd. Hillandale</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: <i>5739 IMMEDIATE CAUSE (a) Metastatic Liver Disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>primary unknown</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Congestive heart failure. Aspiration</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <i>1-5-83</i> to <i>11-12-83</i> , that (I) (we) lost saw the deceased alive on <i>12-10-83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <i>H. Bahar</i>	
22c. DATE SIGNED <i>11-13-83</i>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>HADI BAHAR</i>		22e. ADDRESS <i>8278 Wisconsin Ave. Bethesda</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>NOV. 16, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>ARMON CEM.</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>GREAT FALLS VA</i>		24. FUNERAL DIRECTOR NAME <i>John F. DeVol</i>		25. DATE REC'D BY REGISTRAR <i>NOV 17 1983</i>	
26. REGISTRAR'S SIGNATURE <i>John J. Gough</i>		27. REGISTRAR'S SIGNATURE			

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE  
WASHINGTON, D.C. 20535

TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK (100-100000)  
SUBJECT: [Illegible]  
RE: [Illegible]  
[Illegible text follows, appearing to be a memorandum or report with several paragraphs of text that is mostly illegible due to fading and bleed-through.]

100-100000



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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>GEORGE DANIEL HICKS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 6 1983</b>			
2b. HOUR <b>2:05</b> a M							
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>SEPTEMBER 14 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>OKLAHOMA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED Off. U.S. NAVY</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>VIRGINIA</b>		13b. COUNTY <b>ARLINGTON</b>		13c. CITY OR TOWN <b>ARLINGTON</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>MELVIN ARTHUR HICKS</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LAURA LEE DUPREE</b>		13e. STREET ADDRESS <b>207 NORTH PARK DRIVE</b> 99999			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>1936-1961</b>		17. INFORMANT <b>MATTIE M. HICKS, 207 NORTH PARK DRIVE.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>1629</b> IMMEDIATE CAUSE (a) <b>WIDELY METASTATIC SMALL CELL CARCINOMA OF LUNG</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 9</b> 19 <b>83</b> , to <b>NOVEMBER 6</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>NOVEMBER 6</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Eugene S. Killeavy</i> M.D.				DEGREE M.D.		22c. DATE SIGNED <b>07 Nov 83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EUGENE S. KILLEAVY, LT, MC, USN</b>				22e. ADDRESS <b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/9/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR NAME <b>Murphy Funeral Home/4510 Wilson Blvd. Arlington</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 9 1983</b>			
				25b. REGISTRAR'S SIGNATURE <i>John A. Smith</i>			

30619

John G. Jones

3 0 6 2 0 12: No a

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR						REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Raymond T. Higgins</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 22, 1983</b>		2b. HOUR P M <b>12 P</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 30 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>84</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4977 Battery Lane</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Army Officer</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. ARMY</b>		13a. USUAL RESIDENCE (NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>20814</b> <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>MILES J. HIGGINS</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY BARRETT</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4977 Battery Lane Apt. 415</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1944-1964</b>		17. INFORMANT <b>Richard E. Higgins</b>		17. ADDRESS <b>12602 Northpoint Lane Laurel, Md. 20708</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>5850</b> IMMEDIATE CAUSE (a) <b>PNEUMONIA.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHRONIC RENAL DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION ____		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ____		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ____ P.M. 19 ____		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) ____			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) ____		21f. LOCATION STREET CITY OR TOWN COUNTY STATE ____			
22a. I certify that (I) (this hospital) attended the deceased from <b>11-22-1983</b> to <b>11-22-1983</b> , that (I) (we) last saw the deceased alive on <b>11-22-1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Roland Imperial MD</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-23-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Roland Imperial, M.D.</b>				22e. ADDRESS <b>4977 Battery La. Beth., MD 20814</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/25/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l. CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington, Va.</b>	
24. FUNERAL DIRECTOR NAME <b>Jos. Gawlers Sons</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Lawler</b>	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 6 2 1

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JAMES ALFRED HILL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-3-83</b>		2b. HOUR <b>4:26 AM</b>		
3. SEX <b>M</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6-30-25</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <b>58</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>JACOMA PARK</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON ADVENTIST</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LABORER</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD.</b>		13b. COUNTY <b>P.G.C.</b>		13c. CITY OR TOWN <b>HYATTS.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ABRAHAM</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FANNIE LANCASTER</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>220-14-2273</b>	
17. INFORMANT <b>HELEN HILL - WIFE - SAME AS 13C</b>		17. ADDRESS <b>7900 KREEGER DR #210</b>		17. CITY OR TOWN <b>HYATTS.</b>		17. STATE <b>MD.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

1629

IMMEDIATE CAUSE (a) **Oat Cell Lung Cancer**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

9 mos.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>Feb 19 83</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE <b>6324 Bellview Rd #460 Hyattsville, MD 20782</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 11-2</b> 19 <b>83</b> , to <b>Nov 83</b> , that (I) (we) last saw the deceased alive on <b>11-2</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Kai-Yin Yung, M.D.</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-3-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Kai-Yin Yung, M.D.</b>		22e. ADDRESS					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11-8-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GEO. WASH. CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>9600 R1995 Rd. Md.</b>	
24. FUNERAL DIRECTOR <b>H. S. Washington &amp; Son - Baltimore</b>		24b. ADDRESS <b>4925 N. H.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

2000 10 10

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30622

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James W. Hill			2a. DATE OF DEATH MONTH DAY YEAR Nov 21, 1983			2b. HOUR 5:00PM			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR July 16, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 20539 Zion Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian		12b. KIND OF BUSINESS OR INDUSTRY School Board	
13a. STATE Md		13b. COUNTY Montg.		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 20539 Zion Road 20879	
14. FATHER'S NAME FIRST MIDDLE LAST John Awkward		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Hill		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					
		16b. SOCIAL SECURITY NO. 214-16-8240		17. INFORMANT Mrs Louise Darden (Daughter) Norristown, Pa					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1629

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

1 yr

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>October</u> , 19 <u>82</u> , to <u>21 Nov</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>4 Nov</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE Donald E. Dillon M.D.				DEGREE M.D.		22c. DATE SIGNED 22 Nov 83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald E. Dillon, M.D.				22e. ADDRESS 18111 Prince Phillip Dr., Olney, Md.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-26-83		23c. NAME OF CEMETERY OR CREMATORY Ash Memorial Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Sandy Spring, Mntg. Md.	
24. FUNERAL DIRECTOR NAME George R. Snowden				25. DATE REC'D BY REGISTRAR NOV 25 1983		26. REGISTRAR'S SIGNATURE James J. Connelley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

3

John G. Smith 1848-1898



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Franklin E. Hodge</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>28</b> YEAR <b>83</b>		2b. HOUR <b>11:45</b> P.M.
3. SEX <b>Male</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH <b>11</b> DAY <b>28</b> YEAR <b>07</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>76</b> YRS.	IF UNDER 1 YEAR MONTHS <b>76</b> DAYS <b>76</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>cab driver</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Maryland</b> 13c. COUNTY <b>Montgomery</b> 13d. CITY OR TOWN <b>Rockville</b>		13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS <b>#401 12109 Village Square Terrace</b> 20852	
14. FATHER'S NAME FIRST <b>Charles</b> MIDDLE <b>W.</b> LAST <b>Hodge</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Lillie</b> MIDDLE <b>Critz</b> LAST <b>Critz</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II 578-24-0214</b>		17. INFORMANT <b>Miami, Florida 33143</b> <b>Frank Hodge 8000 S.W. 81st Dr. #204</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Pulmonary Arrest</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic Carcinoma of Lung</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pneumonia</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 min</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 24</b> , 19 <b>83</b> , to <b>Nov 28</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>Nov 28</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <b>Howard S. Goldstein</b> DEGREE <b>MD</b>				22c. DATE SIGNED <b>11/29/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Howard S. Goldstein</b>				22e. ADDRESS <b>4701 Randolph Rd. Rockville, Md. 20852</b>	
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>12/2/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Maryland Veterans Cemetery, Crownsville, Md.</b> STATE	
24. FUNERAL DIRECTOR NAME <b>Tyson Wheeler Funeral Home, Inc.</b> ADDRESS <b>1331 Rockville Pike Rockville, Md. 20852</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 5 1983</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

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DHMH - 16 50M 4/B2  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. FOR STATE REGISTRAR				26. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Virginia Mae Hoffman				26. DATE OF DEATH MONTH DAY YEAR 11-19-83	
3. SEX Female		4. RACE white		26. HOUR 1330	
5. DATE OF BIRTH MONTH DAY YEAR 3 14 28		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Health Center 5721 Grosvenor		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville	
14. FATHER'S NAME FIRST MIDDLE LAST Paul Barnaby		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Bell		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-26-6491		17. INFORMANT Daughter Betsy Sweeney	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA 1519 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) GASTRIC AREA DUE TO, OR AS A CONSEQUENCE OF (c) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YEAR 3 YEARS		19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 16			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/16/83 11/10 19 83, to date, 1983, that (I) (we) lost saw the deceased alive on 11/16/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Thos G. Nard		DEGREE		22c. DATE SIGNED 11/19/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thos G. Nard		22e. ADDRESS 6116 Robinwood, Bethesda, Md 20817			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 22, 1983		23c. NAME OF CEMETERY OR CREMATORY George Washington	
24. FUNERAL DIRECTOR NAME Francis J. Collins		24b. ADDRESS 500 University Blvd., W. Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR NOV 25 1983	
				25b. REGISTRAR'S SIGNATURE John J. Quinn	

1330

11-14-03

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Female

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EX-  
 ECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.  
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS  
 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,  
 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

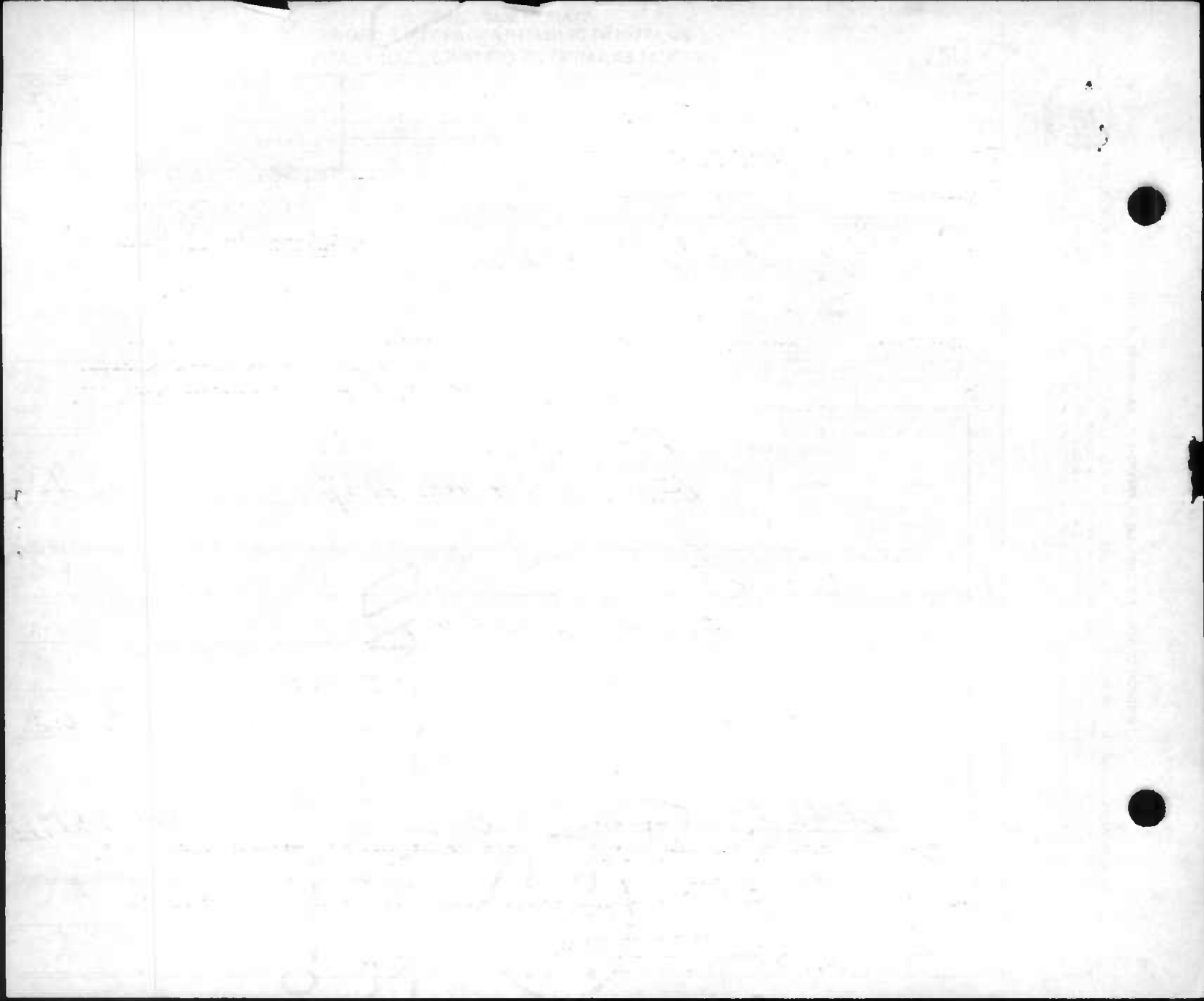
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DHMH - 17  
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STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Sarah Elizabeth Hartman Hoke				2a. DATE KNOWN OF DEATH ESTIMATED Nov. 26, 1983				2b. HOUR 11:45 AM			
3. SEX Female	4. RACE Cauca.	5. DATE OF BIRTH MONTH DAY YEAR Apr. 1, 1896	6. AGE (IN YEARS) LAST BIRTHDAY 87 YRS.	IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Nov 26, 1983			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hospitals Holy Cross				12a. USUAL OCCUPATION (TYPE OF WORK) Administrative Assistant				12b. KIND OF BUSINESS OR INDUSTRY IRS	
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. ST. Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS 3498 Chiswick Drive 20906			
14. FATHER'S NAME FIRST MIDDLE LAST Bradley Hartman Hoke				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Lamar							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-52-5590				17. INFORMANT Niece Marla H. Moore 6803 Wells Parkway University Park, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8880 Pulmonary Embolus DUE TO, OR AS A CONSEQUENCE OF (b) Fracture Rt. Hip DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None											
19a. DATE OF OPERATION 11-10-83				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Fracture Rt. Hip				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. Nov 1983				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fell at home			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Chiswick Ct. Silver Spring Mont. Md.			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE John S. Rogers, M.D.				TITLE (SPECIFY) M.D. Dep.				MEDICAL EXAMINER DATE SIGNED Nov 26, 1983			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS 1919 Seminary Rd. Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL Cremation				23b. DATE Nov. 27, 1983		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia	
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND						25a. DATE REC'D. BY REGISTRAR NOV 28 1983		25b. REGISTRAR'S SIGNATURE John S. Rogers			



FOR Item 18b film 586  
1- STATE 12-8-83 cn  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>NORMA DEAN HOLSTEN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 10 1983</b>		2b. HOUR <b>3:13p M</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>AUG 24 1937</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>46</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>KANSAS</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.		
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL BETHESDA</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>OFFICE MANAGER</b>		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>			13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>ROCKVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>LEONARD</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MILLIE SMITH</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>510-30-3205</b>		17. INFORMANT ADDRESS <b>DONALD HOLSTEN 7049 WOLF TREE LANE, ROCKVILLE</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MULTIPLE CRANIAL LESIONS</b> <b>1991</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ABNORMAL CHEST XRAY Probable Metastatic disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____		MD 28052 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>NOV 6</b> , 19 <b>83</b> , to <b>NOV 10</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>NOV 10</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>R.L. Sollock</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10 Nov 83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R.L. SOLLOCK, LCDR, MC, USNR</b>				22e. ADDRESS <b>NAVAL HOSPITAL BETHESDA MD 20814</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>11-11-1933</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Hines/Rinaldi Funeral Home Silver Spring, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10

CHIEF

THE CHIEF OF POLICE  
CITY OF NEW YORK  
OFFICE OF THE CHIEF OF POLICE  
100 NASSAU ST. NEW YORK 10038  
TELEPHONE 312-1234  
FAX 312-5678  
E-MAIL: CHIEF@NYPD.ORG  
WWW.NYPD.ORG





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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the medical examiner, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30027

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		HOURS MIN.	
Mary - Honick		11 23 83		11 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR IF UNDER 24 HRS.	
Female	White	MONTH DAY YEAR	95 YRS.	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
RUSSIA	U.S.A.		Montgomery MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda	Suburban Hospital	HOMEMAKER	HOME		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
MARYLAND	MONTGOMERY	SILVER SPRING	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	15301 WALLBROOK CT. #3C	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16. SOCIAL SECURITY NO.			
FIRST MIDDLE LAST	FIRST MIDDLE LAST	17. INFORMANT ADDRESS			
ABRAHAM - BORDEN	ROSE - FRADIN	LEONA H. CONN SAME AS #13.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS			
NO	UNKNOWN	LEONA H. CONN SAME AS #13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) 4100 Acute Cardiac Pulmonary Arrest					sudden
DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
	19				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/23, 1983, to 11/23, 1983, that (I) (we) last saw the deceased alive on I NEVER DID, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
ELISA J. MORGNER, M.D.	M.D.	8808 Hodder Hill La. POTOMAC, MD.		11/24/83	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
BURIAL	NOV. 27, 1983	KING DAVID CEMETERY	FALLS CHURCH, FAIRFAX, VIRGINIA		
24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE		
CHAMBERS FUNERAL HOME	SILVER SPRING, M.D.	NOV 30 1983	John J. Coniff		

1914

1. *Phaseolus vulgaris* L.  
2. *Phaseolus vulgaris* L.  
3. *Phaseolus vulgaris* L.  
4. *Phaseolus vulgaris* L.  
5. *Phaseolus vulgaris* L.  
6. *Phaseolus vulgaris* L.  
7. *Phaseolus vulgaris* L.  
8. *Phaseolus vulgaris* L.  
9. *Phaseolus vulgaris* L.  
10. *Phaseolus vulgaris* L.

11. *Phaseolus vulgaris* L.  
12. *Phaseolus vulgaris* L.  
13. *Phaseolus vulgaris* L.  
14. *Phaseolus vulgaris* L.  
15. *Phaseolus vulgaris* L.  
16. *Phaseolus vulgaris* L.  
17. *Phaseolus vulgaris* L.  
18. *Phaseolus vulgaris* L.  
19. *Phaseolus vulgaris* L.  
20. *Phaseolus vulgaris* L.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Virginia Cecilia Hooker</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>18</b> YEAR <b>83</b>			2b. HOUR <b>5:45</b> M					
3. SEX <b>Female</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH <b>8</b> DAY <b>18</b> YEAR <b>43</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>40</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Harrisonburg, Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery Cty., MD</b>					
10. CITY OR TOWN OF DEATH <b>Silverspring, Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Private</b>			
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silverspring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>8860 Pineybranch Rd.</b>		
14. FATHER'S NAME FIRST <b>Thomas</b> MIDDLE <b>Mason</b> LAST <b>Mason</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Eleanor</b> MIDDLE <b>Moore</b> LAST <b>Moore</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>579-54-8229</b>			17. INFORMANT ADDRESS <b>Silverspring</b> <b>William Hooker (Husband) 8860 Pineybranch Md.</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

**5185**

IMMEDIATE CAUSE (a)

**CARDIO RESPIRATORY ARREST.**

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

**.1 hr.**

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **ADULT RESPIRATORY DISTRESS SYNDROME  
AND RESPIRATORY FAILURE**

**38 hrs.**

DUE TO, OR AS A CONSEQUENCE OF

(c) **MASSIVE PULMONARY HAEMORRHAGE AND ASPIRATION PNEUMONIA**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

**DAUTEON CHRONIC RELUCTANT DEEPVEN THROMBOSIS (2) PROLONGED PROTHROMBINE TIME (3) SYSTEMIC  
LUPUS ERYTHEMATOSUS (4) BRONCHITIS (5) BRONCHIAL ASTHMA.**

19a. DATE OF OPERATION

**NA**

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

**NA**

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. **19**

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 - PART 1 OR PART 2)

**NA**

21d. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  
**NA**

21f. LOCATION  
STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from **8-30 AM 17 NOV 1983** to **NOV 18 1983**, that (I) (we) last saw the deceased alive on **NOV 18 1983**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

**Seldapi MD**

DEGREE

**MD**

ATTENDING PHYSICIAN

MEDICAL DIRECTOR ☒

STAFF PHYSICIAN ☐

22c. DATE SIGNED

**NOV 19 1983**

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

**SHRINIVAS R. UDAPI, MD**

22e. ADDRESS

**6005 Landover Rd. CHEVERLY, MD 20785**

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

**Burial**

23b. DATE

**11/23/83**

23c. NAME OF CEMETERY OR CREMATORY

**Lincoln Memorial**

23d. LOCATION  
CITY OR TOWN

**Suitland**

COUNTY

**PG**

STATE

**Md.**

24. FUNERAL DIRECTOR  
NAME

**BN Horton**

25a. DATE RECD. BY REGISTRAR

**DEC 7 1983**

25b. REGISTRAR'S SIGNATURE

**John E. Carver**

ADDRESS  
**600 Kennedy St NW Wash DC**



TO: [illegible]  
 FROM: [illegible]  
 SUBJECT: [illegible]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be kept for 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP \_\_\_\_\_

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 6 2 7

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST <b>EVOLYN Knotts HOTTEL</b>		MONTH DAY YEAR <b>11 24 1983</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>	
5. DATE OF BIRTH MONTH DAY YEAR <b>April 5, 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Medical</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Mont.</b>	
13c. CITY OR TOWN <b>Brookeville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS <b>2001 Brighton Dam Road</b>		13f. STREET ADDRESS <b>20833</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Temple Knotts</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth - Harrington</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>218-52-5954</b>	
17. INFORMANT <b>Amey Childs</b>		ADDRESS <b>1911 Br ighton Dam Rd. Brookeville, Md. 20833</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>4300</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic cerebral artery aneurysm</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCD</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>22 hrs</b> <b>22 hrs</b> <b>years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/23</b> 19 <b>83</b> , saw the deceased alive on <b>11/23</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <b>C. H. Ligon MD</b>	
22c. DATE SIGNED <b>11/23/83</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>C. H. Ligon MD</b>	
22e. ADDRESS <b>1811 P. Philip Dr., Olney, Md. 20832</b>		22f. DATE RECEIVED BY REGISTRAR <b>NOV 28 1983</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 27, 1983</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Salem Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brookeville Mont. Md.</b>	
24. FUNERAL DIRECTOR <b>Francis H. Barber</b>		24b. DATE RECEIVED BY REGISTRAR <b>NOV 28 1983</b>	
24c. LAYTONSVILLE, MD. 20879		24d. REGISTRAR'S SIGNATURE <b>J. J. Conner</b>	

MEMORANDUM FOR THE RECORD  
SUBJECT: [Illegible]  
DATE: [Illegible]

1. [Illegible]  
2. [Illegible]  
3. [Illegible]  
4. [Illegible]  
5. [Illegible]  
6. [Illegible]  
7. [Illegible]  
8. [Illegible]  
9. [Illegible]  
10. [Illegible]

[Large block of illegible handwritten notes and signatures]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Marie J. Howarth</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>11/24/83</b>		2b. HOUR <b>6:51 AM</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10 28 94</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b>	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>New York</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD	
10. CITY OR TOWN OF DEATH <b>Rockville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (DO NOT INCLUDE CITY, STREET ADDRESS) <b>Rockville Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>home</b>
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Potomac</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George E. Naples</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Brown</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>086-22-8757</b>		17. INFORMANT ADDRESS <b>Philmor Dahlberg same as 13c</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>4149</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ischemic heart dis. pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis. senile transition. dementia</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Urinary tract infection. Calcific aortic stenosis.</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART I OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/19/83</b> to <b>11/24/83</b> , that (I) (we) last saw the deceased alive on <b>11/19/83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Thomas W. Garvey III, MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/24/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>TITOMAS W. GARVEY III, MD</b>		22e. ADDRESS <b>11510 Old Georgetown Rd. Rockville MD</b>			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>Burial</b>		23b. DATE <b>11/28/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moravin Cemetery</b>	
23d. LOCATION (CITY OR TOWN, COUNTY, STATE) <b>Staten Island, New York</b>		23e. DATE REC'D. BY REGISTRAR <b>NOV 30 1983</b>			
23f. REGISTRAR'S SIGNATURE <b>John J. Connel</b>		23g. REGISTRAR'S SIGNATURE <b>John J. Connel</b>			

24. FUNERAL HOME, INC.  
**Tyson Wheeler Funeral Home, Inc.**  
**1331 Rockville Pike Rockville, Md. 20852**

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE



WV 80 0000 8000 0000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

Cleared by Dr. Francis Mayle

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST Schell Stutzman Hoye				November 1, 1983			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 2, 1916		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 67	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7819 English Way		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cert. Public Acct.		12b. KIND OF BUSINESS OR INDUSTRY Accounting	
13a. STATE Md. 20817		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Paul -- Hoye		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elinor -- Hinebaugh		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 217-01-4489	
17. INFORMANT		ADDRESS Josephine J. Hoye, Same address as #13.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Neuroblastoma of brain</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>1919</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 1/2 mos
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1-12</u> , 19 <u>55</u> , to <u>11-1</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>Sept 19 83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE DEGREE Joseph J. Wallace, MD. ATTENDING PHYSICIAN				22c. DATE SIGNED 11-1-83		22d. MEDICAL STAFF DIRECTOR <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph J. Wallace, MD.				22f. ADDRESS 5272 River Rd. Beth., Md. 20816			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/4/83		23c. NAME OF CEMETERY OR CREMATORY Garrett County Mem. Gdns.		23d. LOCATION CITY OR TOWN COUNTY STATE Oakland, Maryland	
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave., NW, Washington, D.C. 20016				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE NOV 04 1983	



20% COMOVOL

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30632

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>William Lars Hudson</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 18, 1983</b>		2b. HOUR <b>3:25 P<sub>M</sub></b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 24, 1935</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>48</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NIH Clinical Center, Bethesda, Md.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Finance Ofcr.</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>	
13a. STATE <b>Virginia</b>			13b. COUNTY <b>Arlington</b>	13c. CITY OR TOWN <b>Arlington</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph C Hudson</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillian E Larson</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1958-62</b>	17. INFORMANT ADDRESS <b>Jane A. Hudson (sister) 109 Hickory St. Maryvale, Tn 37801</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>Pan lobar consolidating pneumonia</b> IMMEDIATE CAUSE (a) <b>4810</b> DUE TO, OR AS A CONSEQUENCE OF <b>Visceral congestion and edema</b> (b) <b>with organomegaly of liver, spleen, kidney</b> Secondary DUE TO, OR AS A CONSEQUENCE OF <b>meningeal clouding and right ventricular dilatation to</b> (c) <b>cerebral swelling</b> suggesting meningitis and slight					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>AIDS</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 11, 1983</b> to <b>November 18, 1983</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>November 18, 1983</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.					
22b. SIGNATURE <b>Richard J. Sveum MD</b>		DEGREE		22c. DATE SIGNED <b>11/20/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RICHARD J. SVEUM</b>		22e. ADDRESS <b>National Institutes of Health Clinical Center, Bethesda, Md. 20205</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>	23b. DATE <b>11-20-83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematory</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>		
24. FUNERAL DIRECTOR <b>Marshall's Funeral Home 4217 9th St NW: Washington, D.C.</b>			25. DATE REC'D BY REGISTRAR <b>NOV 28 1983</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use on the burial-transit permit. Then please remove carbonpages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 999999

CONFIDENTIAL

CONFIDENTIAL

EDWARD J. SMITH  
M.D.

X

11/15/53

CONFIDENTIAL

BP

DHMH - 16 50M 1/76  
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of a case.

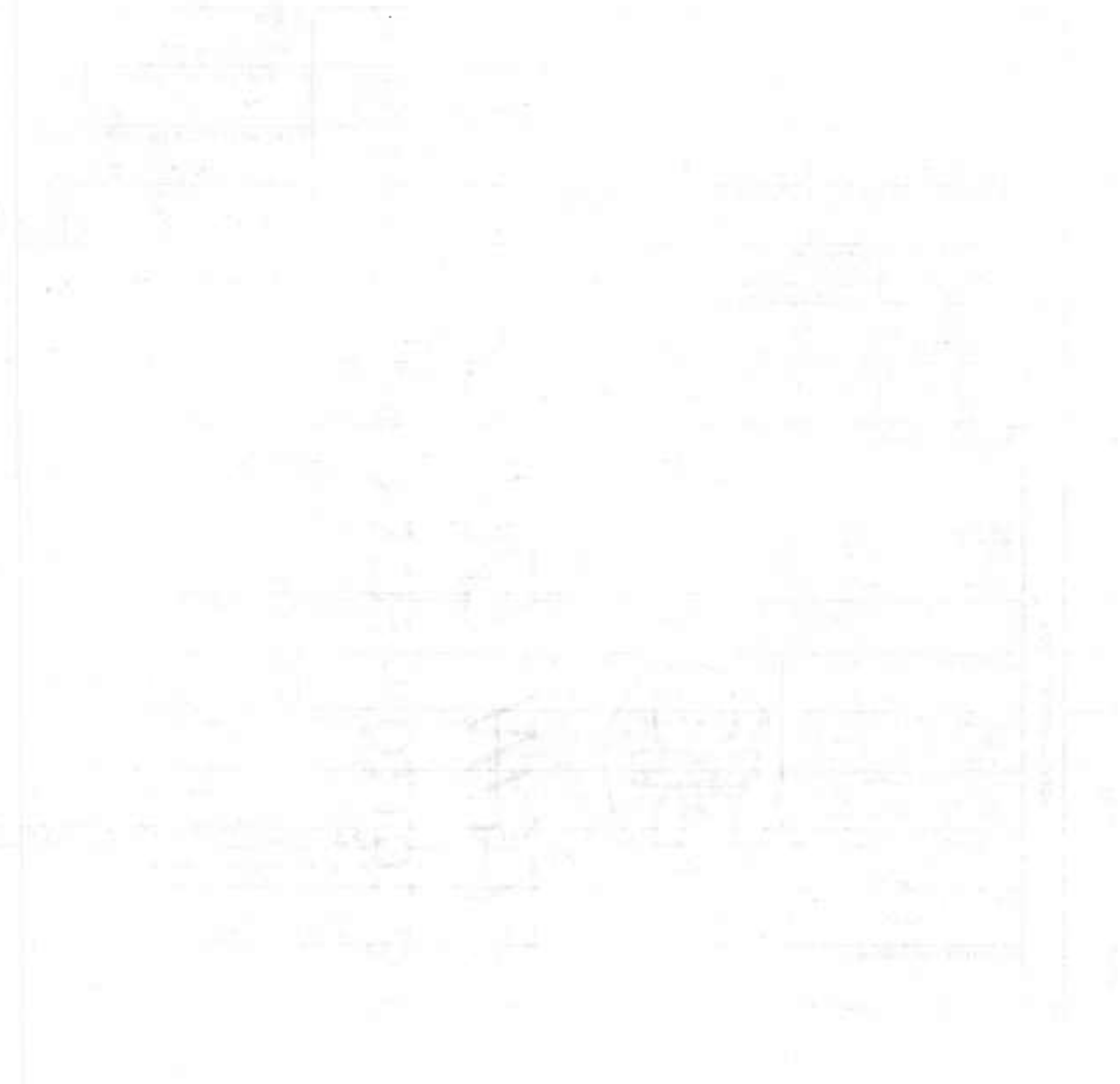
FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) May H. Irwin			2a. DATE OF DEATH MONTH DAY YEAR November 4, 1983		2b. HOUR P 6:25 P M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 26, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS. MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.		
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wilson Health Care Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) President		12b. KIND OF BUSINESS OR INDUSTRY Retail Stone		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Hudson Harlan			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sara Stephens					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 218 16 0251		17. INFORMANT Daughter Sandra Kelly ADDRESS 13821 Deakins Ln. Germantown, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY Arrest</u> <u>2384</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>POLYCYTEMIA VERA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u> <u>6 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>June 1</u> , 19 <u>83</u> , to <u>November 4</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>Nov 4</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.								
22b. SIGNATURE <u>Luis F. Bentolila</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Nov. 5, 1983		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Luis F. Bentolila, M.D.				22e. ADDRESS 5480 Wisconsin Ave. Chevy Chase, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE NOV. 8, 1983		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia		
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY HOMES, P.A., BETHESDA, MARYLAND				25a. DATE REC'D. BY REGISTRAR NOV 7 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>		

MEDICAL CERTIFICATION



BP

DHMH - 16 50M 1/B1  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				30634 PHILIP W. JACKSON, SR.			
1 - FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) <b>Philip Jackson, SR</b>				2a DATE OF DEATH MONTH DAY YEAR <b>11/19/83</b> 2b HOUR <b>11 45 AM</b>			
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>4/26/91</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>82</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON DC</b>		7b CITIZEN OF WHAT COUNTRY? <b>US</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD.</b>	
10 CITY OR TOWN OF DEATH <b>Takoma Park</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sligo Gardens</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RAILROAD UNION STATION - POLICE</b>		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE <b>MD</b>		13b COUNTY <b>MONT</b>		13c CITY OR TOWN <b>KENNINGTON</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>MARCUS P. JACKSON</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ADDIE L. BOTT</b>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
16b SOCIAL SECURITY NO. <b>578-03-4287</b>		17 INFORMANT <b>PHILIP W. JACKSON, JR.</b>		ADDRESS <b>11444 CONN. AVENUE</b>			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrests.</b> <b>4149</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Artery Disease.</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Chronic obstructive lung disease, Old CVA, atrial fibrillation</b>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <b>11/15</b> , 19 <b>83</b> , to <b>11/19</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>11/15</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <b>Antonio G. Uy</b>				DEGREE <b>MD</b>		22c DATE SIGNED <b>11/19/83</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANTONIO G. Uy</b>				22e ADDRESS <b>831 Univ. Blvd E. #25 S.S. Md 20903</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b DATE <b>Nov. 21-1983</b>		23c NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Crematory</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore MD</b>	
24 FUNERAL DIRECTOR NAME <b>Takoma Funeral Home Jackson</b>				25a DATE REC'D. BY REGISTRAR <b>NOV 22 1983</b>			
				25b REGISTRAR'S SIGNATURE <b>John J. Connelley</b>			

11/17/20

Philip Jackson, Jr.

11/17/20

WHITE

Male

11/17/20

X

11/17/20

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30635

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ISADOR JACOBSON</b>			2a DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 28, 1983</b>		2b HOUR <b>10:30 PM</b>	
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>MAY 23, 1918</b>		
6 AGE (IN YEARS LAST BIRTHDAY) <b>65</b>		7 UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		8 UNDER 24 HRS HOURS MIN. <b>YRS.</b>		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>		7b CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		9 <b>BALTIMORE CITY OR COUNTY OF DEATH</b> <b>MONTGOMERY COUNTY</b> MD.		
10 CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1211 CRESTHAVEN DRIVE</b>		12a USUAL OCCUPATION (TO INCLUDE OR MOST OF WORKING LIFE) <b>SALES REPRESENTATIVE</b>		
12b KIND OF BUSINESS OR INDUSTRY <b>WHOLESALE LIQUOR</b>		13a STATE <b>MARYLAND</b>		13b COUNTY <b>MONTGOMERY</b>		
13c CITY OR TOWN <b>SILVER SPRING</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>1211 CRESTHAVEN DRIVE</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>REUBEN JACOBSON</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ROSE ODENOV</b>		16a WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		
16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>203-01-6518</b>		17 INFORMANT ADDRESS <b>ELEANOR E. JACOBSON, 1211 CRESTHAVEN DRIVE, SILVER SPRING, MARYLAND</b>				

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**CARDIAC Arrest**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**Sudden**4149  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **CORONARY ARTERY Disease****10 yrs.**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

**1975 - Old MYOCARDIAL INFARCT**

MEDICAL CERTIFICATION

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <b>1975</b> to <b>11-28</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>11-28</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <b>Herbert Tanenbaum</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>11/29/83</b>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. HERBERT TANENBAUM, M. D.</b>		22e ADDRESS <b>5480 WISCONSIN AVENUE CHEVY CHASE, MARYLAND 20815</b>					

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b DATE <b>11/30/1983</b>		23c NAME OF CEMETERY OR CREMATORY <b>JUDEAN MEMORIAL GARDENS</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>OLNEY, MONTGOMERY, MARYLAND</b>	
24 FUNERAL DIRECTOR <b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</b>				25 DATE REC'D. BY REGISTRAR <b>DEC 2 1983</b>		25 REGISTRAR'S SIGNATURE <b>John L. Gault</b>	
232 CARROLL STREET, N. W., WASHINGTON, D. C.							

BP

DHMH-16 25M  
(VRA 15, 4) 1/79

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be retained by the hospital or attending physician.

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2-2-40

CARDINAL STREET

10-10-40

CARDINAL STREET DISTRICT

1932 - Old - 10 - 10 - 10

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DEC 2 1940

DUPLICATE FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>TIFFANY MARIE JAMES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 2 1983</b>		2b. HOUR <b>1:38 P.M.</b>							
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>NOVEMBER 2 1982</b>		6. AGE (IN YEARS, LAST BIRTHDAY) 1 YRS. <b>1</b>		IF UNDER 1 YEAR MONTHS DAYS <b>1</b>		IF UNDER 24 HRS HOURS MIN. <b>1</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.						
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Child</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>n/a</b>				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>NEW YORK</b>			13b. COUNTY <b>CLINTON</b>		13c. CITY OR TOWN <b>PLATTSBURGH</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>5072 D IDAHO AVENUE</b> 99999			
14. FATHER'S NAME FIRST MIDDLE LAST <b>ROBERT THOMAS JAMES</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>WANDA JEAN INFANTE</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>None</b>		17. INFORMANT ADDRESS <b>WANDA JEAN JAMES, 5077 D IDAHO AVENUE</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4160</b> IMMEDIATE CAUSE (a) <b>PULMONARY HYPERTENSION</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 25</b> , 19 <b>83</b> , to <b>NOVEMBER 2</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>NOVEMBER 2</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Joseph C. Stegman</i>						DEGREE		22c. DATE SIGNED <b>11/7/83</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOSEPH C. STEGMAN, LCDR, MC, USNR</b>						22e. ADDRESS <b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Nov. 7, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Peter's Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Plattsburgh, New York</b>					
24. FUNERAL DIRECTOR NAME <b>Capitol Funeral Service, Falls Church,</b>						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR <i>James G. Smith</i>				

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

10-10-1961

10-10-1961



CHIEF

James L. Smith

880 0 1 000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30637

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HOWARD E. JARBOE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Nov 25 1983</b>		2b. HOUR M <b>1045P</b>		
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 18 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>78</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hosp</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Steamfitter</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Jarboe</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Susie Cole</b>		13e. STREET ADDRESS / ZIP CODE <b>520 Kerwin Road 20901</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>577-10-3539</b>		17. INFORMANT ADDRESS <b>Johanna M. Jarboe Wife Same as 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia, renal failure</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebrovascular accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Arteriosclerotic cardiovascular disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>1 month</b> <b>10 years</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION <b>11/21/83</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Gastrostomy, unable to swallow</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct. 17, 1983</b> , to <b>Nov. 25, 1983</b> , that (I) (same) last saw the deceased alive on <b>Nov. 25, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Raymond Bradshaw, Jr. MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Raymond Bradshaw, MD.</b>				22e. ADDRESS <b>345 University Blvd, W Silver Spring, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 28, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rockville Montgomery Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 2 1983</b>			
ADDRESS <b>500 University Blvd., W. Silver Spring, Md.</b>				REGISTRAR'S SIGNATURE <b>John J. White</b>			

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Howard A. Edwards

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Nell C. Jefferson</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 17, 1983</b>		2b. HOUR <b>2<sup>30</sup> A<sup>M</sup></b>						
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 7, 1906</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) YRS. <b>77</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ala.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery, MD.</b>					
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Fernwood Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Librarian</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>D.C. School</b>			
13a. STATE <b>none</b>		13b. COUNTY <b>none</b>		13c. CITY OR TOWN <b>Wash. D.C.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3001 Veazy Terrace, N.W.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Stephen Amzi Childs</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lena Bates</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>					
16b. SOCIAL SECURITY NO. <b>518-63-1317</b>			17. INFORMANT ADDRESS <b>1666 K St. N.W. Washington, D.C.</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>7109</b> IMMEDIATE CAUSE (a) <b>Ascending Urinary Tract Infection</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diffuse Connective Tissue Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>4-1-83</b> to <b>11-17-83</b> , that (I) (we) lost saw the deceased alive on <b>11-14-83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Marvin Fuchs M.D.</b>						DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>Nov. 17, 1983</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Marvin Fuchs M.D.</b>						22e. ADDRESS <b>5315 Conn. Ave. N.W. Washington, D.C.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Nov. 22, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>				
24. FUNERAL DIRECTOR NAME <b>DeVol Funeral Home</b>						25. DATE REC'D. BY REGISTRAR <b>NOV 22 1983</b>					
ADDRESS <b>Washington, D.C.</b>						REGISTRAR'S SIGNATURE <b>John J. Carver</b>					

MEDICAL CERTIFICATION

NOV 23 1963



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in duplicate by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Estelle J. Jenkins</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11 27 83</b>			
3. SEX <b>Female</b>				2b. HOUR <b>3:55 P</b>			
4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>October 14 1891</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b>		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Kensington</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Kensington Gardens Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>NIH</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Kensington</b>		13e. STREET ADDRESS / ZIP CODE <b>10406 Summit Avenue 20895</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Joy</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Georgianne DeMarr</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>579-22-3026</b>		17. INFORMANT <b>Daughter</b> ADDRESS <b>1025 Lossing Avenue Colonial Beach, Va. 22443</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4140 Congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>2 yrs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>2 yrs</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1980</b> , 19 <b>11-27</b> <b>83</b> , to <b>11-27</b> <b>83</b> , that (I) (last saw the deceased alive on <b>11-24</b> <b>83</b> , and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above, (I) (I) (did) (did) the body after death.							
22b. SIGNATURE <b>George Sengstack M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>11-27-83</b>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>George Sengstack</b>				22f. ADDRESS <b>9241 Columbia Blvd. S.S. Md. 20910</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 30, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Episcopal Chapel</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Aquasco Pr. Geo. Md.</b>	
24. FUNERAL DIRECTOR <b>Francis J. Collins</b> NAME ADDRESS <b>500 University Blvd., W. Silver Spring, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 2 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30640

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Emil H Jerabek</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11 30 83</b>		2b. HOUR <b>10:45 PM</b>	
3. SEX <b>Male</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 29 1881</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>102</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MINNESOTA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD</b>	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BANKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>BANK</b>	
13a. STATE <b>MD</b>		13b. CITY OR TOWN <b>Kensington</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>3509 Kent St 20895</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John J. Jerabek</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eleanor Straka</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>UNKNOWN</b>			
16b. SOCIAL SECURITY NO. <b>477-18-2349</b>		17. INFORMANT <b>MILAN JERABEK</b>		17. ADDRESS <b>Kensington, MD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Generalized Atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4409</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <b>DIABETES</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11 30 83</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11/24 1983</b> to <b>11/30 1983</b> , that (I) (we) last saw the deceased alive on <b>11/30 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Richard H. Pollen MD</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/2/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RICHARD H. POLLEN MD</b>		22e. ADDRESS <b>10400 Greenbelt Ave, Kensington MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Dec 83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee Funeral Home</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington</b>	
24. FUNERAL DIRECTOR NAME <b>Helen L. H. 9013 Annapolis</b>		ADDRESS <b>MD 20706</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 13 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>	

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE  
WASHINGTON, D.C. 20535

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Catherine Hobbs Johnson.			2a. DATE OF DEATH MONTH DAY YEAR 11 5 83		2b. HOUR 3:30 A M	
3. SEX Female.		4. RACE White.		5. DATE OF BIRTH May 5, 1914 YEAR MONTH DAY		
6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery. MD.				
10. CITY OR TOWN OF DEATH Silver Spring.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 15410 Good Hope Rd. S. S. Md.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker.		
12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS 15410 Good Hope Rd. S. S.				
13b. COUNTY Montgomery.		13c. CITY OR TOWN Silver Spring.		13d. INSIDE CITY LIMITS? NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Grover C. Hobbs.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle Welch.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. 578-26-5716		17. INFORMANT ADDRESS (Son) George Johnson Jr.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1539

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

3 mos

29 mos

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION Aug 28 83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cordectomy - For Pain		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> 19 <u>81</u> , to <u>Nov 5</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>Sept 28</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Philip H. Philbin MD				22c. DATE SIGNED 11-5-83		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Philip H. Philbin	
22e. ADDRESS 106 Irving St NW Wash DC 20010				22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			

23a. PLACE OF BURIAL, REMOVAL Burial		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION Burtonsville Montg. Md.	
24. FUNERAL DIRECTOR NA Takoma Funeral Home.		25a. DATE REC'D. BY REGISTRAR NOV 9 1983		25b. REGISTRAR'S SIGNATURE John J. Carroll		25c. ADDRESS 254 Carroll St. N. W. D	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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1911

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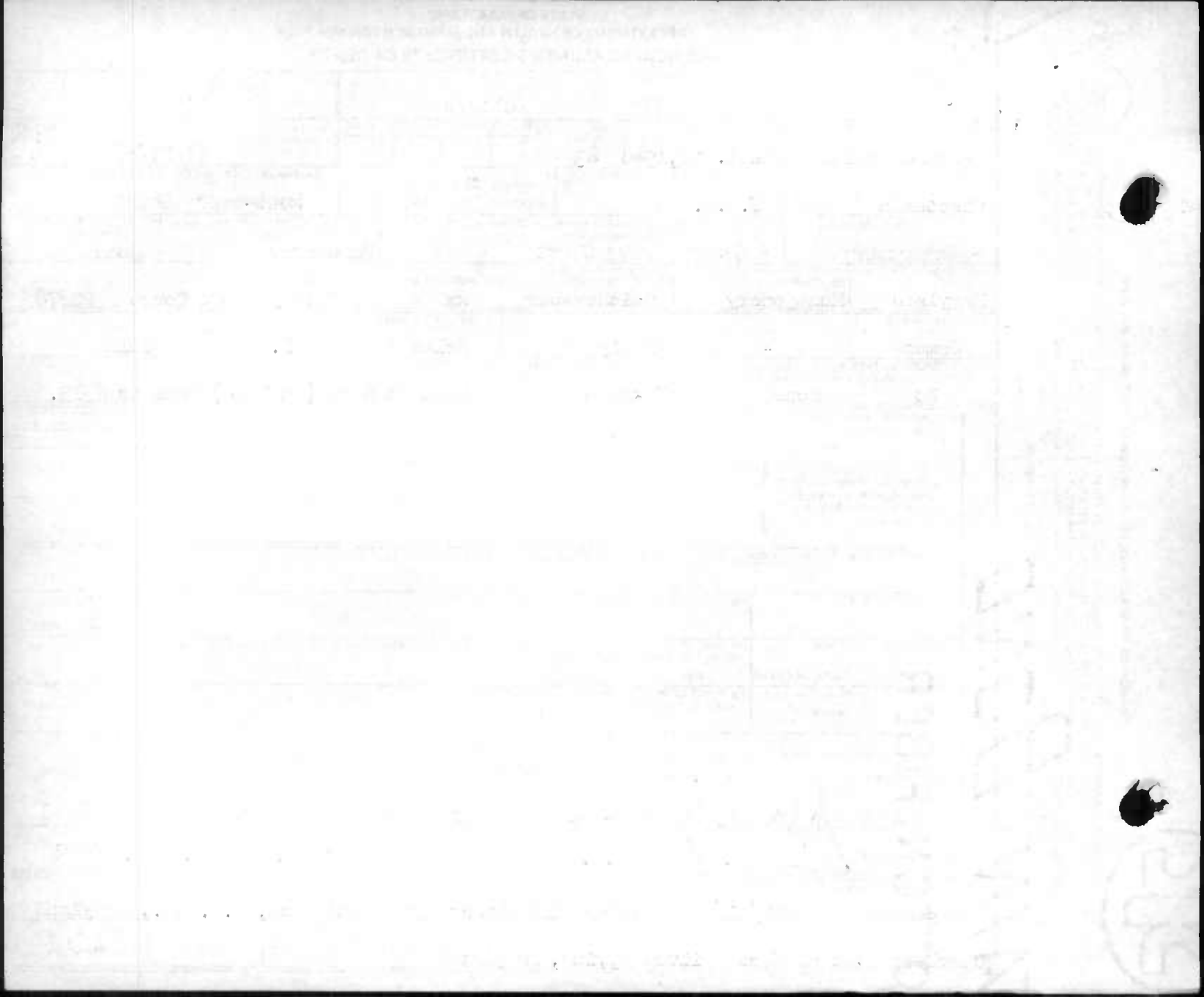


JOHNSON, J. W. 1911

JOHNSON, J. W. 1911

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
FOR# 18, 22a FilmG587 1- STATE REGISTRAR 1/12/84 kam <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b>									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)						2a. DATE KNOWN OF DEATH		2b. HOUR	
FIRST MIDDLE LAST Eve Lally Johnson						<input checked="" type="checkbox"/> MONTH DAY YEAR <input type="checkbox"/> 11/21/83		<input checked="" type="checkbox"/> 7:40 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD		7d. HOUR	
Female	White	Sept. 20, 1940	43 YRS.	MONTHS DAYS	HOURS MIN.	11/21/83		A M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Wisconsin		U.S.A.				Montgomery County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Gaithersburg		9 Cherry Grove Court				Homemaker		Home	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Montgomery		Gaithersburg		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		9 Cherry Grove Court 20878	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
James - Lally				Helen L. Golk					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No				None		Unknown Robert Johnson (Husband) Same as # 13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 0382 IMMEDIATE CAUSE (a) <u>Pneumococcal Septicemia</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 11/21/83	
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS					
Ann M. Dixon, M.D.				111 Penn St., Balto., Md. 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Cremation		Nov/23/83		Cedar Hill Crematory		Suitland, P.G. Co., Maryland			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Chambers Funeral Home				Silver Spring, Maryland		NOV 28 1983		John J. Connel	





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 6 4 3

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Maude E Johnson</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 - 7 - 83</b>		2b. HOUR <b>1:16 P.M.</b>
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>FEB. 12, 1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.		
10. CITY OR TOWN OF DEATH <b>Rockville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montg.</b>	13c. CITY OR TOWN <b>Rockville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>614 N. Horner's Lane 20850</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>ROGER Williams</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LAURA JOHNSON</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-30-4056</b>		17. INFORMANT ADDRESS <b>Helen JOHNSON (sister) same as #13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOGENIC SHOCK</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ACUTE MYOCARDIAL INFARCTION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>ATHEROSCLEROTIC HEART DISEASE</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 HOURS</b> <b>8 HOURS</b> <b>10 YEARS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>DIABETES MELLITUS - URICACEMIC BLAODRA - HYPERTENSIVE VASCULAR DISEASE</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 19, 1980</b> to <b>NOVEMBER 7, 1983</b> , that (I) (we) lost saw the deceased alive on <b>NOVEMBER 7, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE 				22c. DATE SIGNED <b>11/7/83</b>	
22d. PHYSICIAN'S NAME <b>GREGORIO LOPEZ MD</b>				22e. ADDRESS <b>1315 E DEER PARK DR - GAITHERSBURG</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11-12-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>	
23d. LOCATION (CITY OR TOWN) <b>Silver Spring Montg. Md.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>George R. Snowden 246 N. Wash. St. Rockville, Md.</b>			
25a. DATE REC'D. BY REGISTRAR <b>NOV 9 1983</b>		25b. REGISTRAR'S SIGNATURE 			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

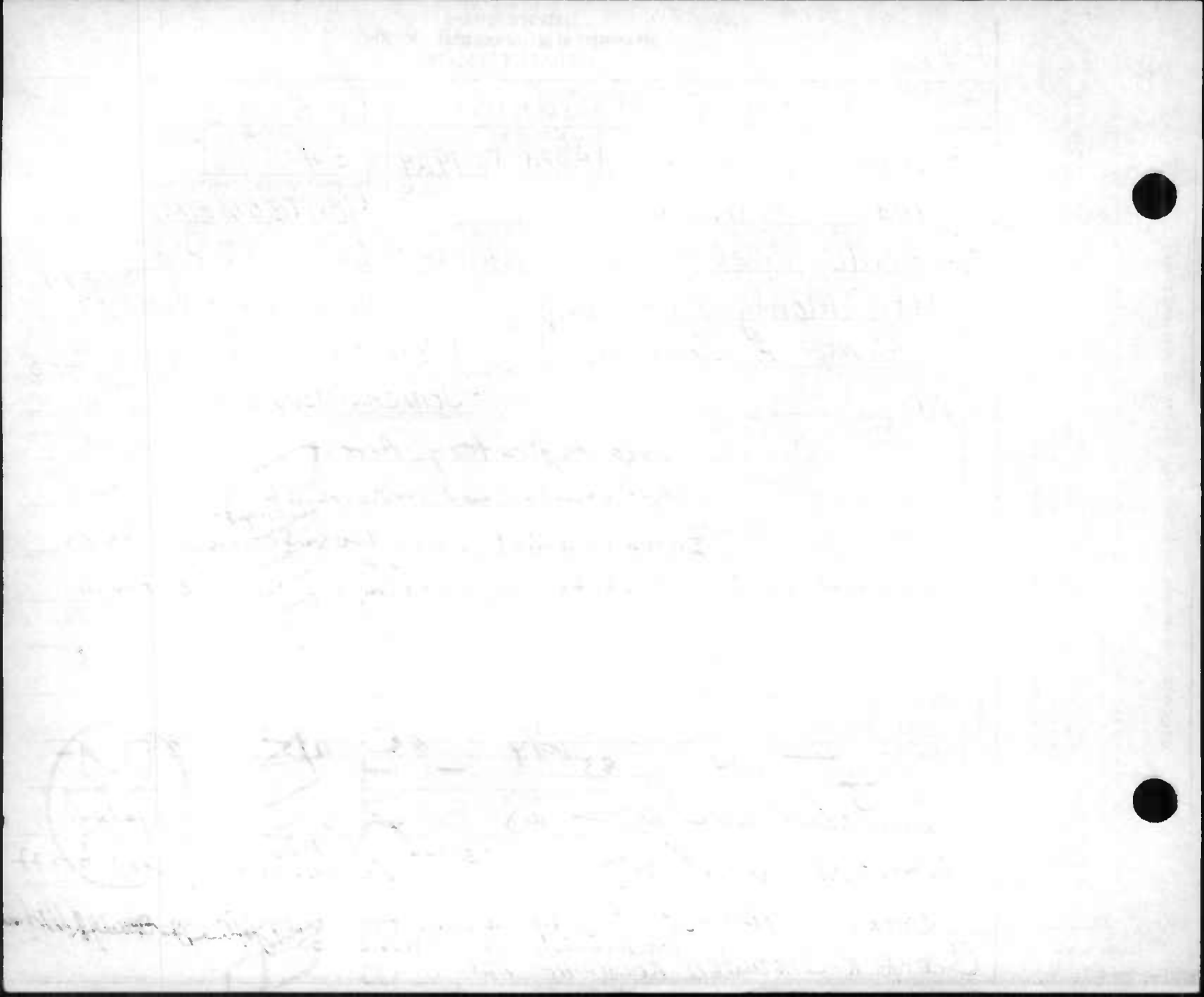
REG. NO.

30644

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <u>RUTH E. JOHNSON</u>			2a. DATE OF DEATH MONTH <u>11</u> DAY <u>5</u> YEAR <u>83</u>			2b. HOUR <u>1945</u> M					
3. SEX <u>Female</u>		4. RACE <u>BLACK</u>		5. DATE OF BIRTH MONTH <u>April</u> DAY <u>1</u> YEAR <u>1929</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>54</u> YRS.		IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>		IF UNDER 24 HRS HOURS <u></u> MIN. <u></u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>MONTGOMERY</u> MD.					
10. CITY OR TOWN OF DEATH <u>Rockville</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>SHADY GROVE ADVENTIST HOSP.</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Laundry Worker</u>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <u>Md.</u>		13b. COUNTY <u>Montg.</u>		13c. CITY OR TOWN <u>Gaithersburg</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>9914 Forest View Pl.</u>			
14. FATHER'S NAME FIRST <u>George E.</u> MIDDLE <u></u> LAST <u>JOHNSON</u>				15. MOTHER'S MAIDEN NAME FIRST <u>Florence E.</u> MIDDLE <u>Diggs</u> LAST <u></u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NOT OR UNKNOWN) <u>No</u> (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.				17. INFORMANT <u>Janet JOHNSON (daughter)</u> ADDRESS <u>19769 Crystal Rock G'burg, Md. Dr.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Septicemia and cardiovascular collapse</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Intracranial chondrosarcoma</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immed</u> <u>10 d</u> <u>3 yrs</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>panophthalmitis, Diabetes, hypocalcemia, Azotemia</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>10/4</u> 19 <u>83</u> to <u>11/5</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>11/4</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we would, did not, view the body after death.)											
22b. SIGNATURE <u>Robert Millman MD</u>				DEGREE <u>MD</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11/7/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Robert Millman, MD</u>				22e. ADDRESS <u>15 E Deer Park Dr Gaithersburg, Md 20877</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>				23b. DATE <u>11-11-83</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial Cem.</u>		23d. LOCATION CITY OR TOWN <u>Sandy Spring</u> COUNTY <u>Montg.</u> STATE <u>Md.</u>			
24. FUNERAL DIRECTOR NAME <u>George R. Snowden</u> ADDRESS <u>244 N. Wash. St. Rockville, Md.</u>				25. DATE REGD. BY <u>NOV 9 1983</u> REGISTRAR'S SIGNATURE <u></u>							

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 30645	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Alice</u> MIDDLE <u>S.</u> LAST <u>Jones</u> <u>Alice S. Jones</u>						2a. DATE OF DEATH MONTH DAY YEAR <u>11-18-83</u>		2b. HOUR <u>11:20 P.M.</u>			
3. SEX <u>FEMALE</u>		4. RACE <u>WHITE</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>10-8-1883</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>100</u> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>ENGLAND</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>MONTGOMERY</u> MD.					
10. CITY OR TOWN OF DEATH <u>BETHESDA</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>FERNWOOD NURSING HOME</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>HOMEMAKER</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>			
13a. STATE <u>MD. 20817</u>		13b. COUNTY <u>MONTG.</u>		13c. CITY OR TOWN <u>BETHESDA</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>6530 DEMOCRACY BLVD.</u>			
14. FATHER'S NAME FIRST <u>CHARLES</u> MIDDLE <u>SUTTON</u> LAST <u>SUTTON</u>				15. MOTHER'S MAIDEN NAME FIRST <u>HANNA</u> MIDDLE <u>COOPER</u> LAST <u>COOPER</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>579-60-0221</u>		17. INFORMANT <u>P.O. BOX 984</u> <u>ALICE G. MAY GLENEDEN BEACH, OREGON</u>							
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> <u>4370</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Deaf, Hx pulmonary</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>1973</u> , 19 <u>11/18/83</u> , to <u>11/18/83</u> , that (I) (we) lost saw the deceased die on <u>11-5-</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Lewis H Bibben</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>11/19/83</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>LEWIS H BIBBEN</u>				22e. ADDRESS <u>1145-19TH ST NW WASHINGTON DC 20036</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>11-21-83</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEME</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>SUITLAND P.G. MD.</u>					
24. FUNERAL DIRECTOR NAME <u>JOS. GAWLERS SONS</u> ADDRESS <u>5130 wisconsin ave. nw. wash., d.c.</u>						25a. DATE REC'D. BY REGISTRAR <u>NOV 23 1983</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Linn</u>			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30646

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Effie C. Jones.</b>			2a. DATE OF DEATH <b>Nov. 25, 1983</b>		2b. HOUR <b>9.15 A.</b>	
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>APRIL 7 1890</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>93</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD.</b>		
10. CITY OR TOWN OF DEATH <b>Silver Spring MD</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>11700 Old Columbia Pike</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>	13b. COUNTY <b>PR. GEO</b>	13c. CITY OR TOWN <b>LAUREL</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>1200 SNOWDEN PLACE 20707</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>GILL</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>NOT AVAILABLE</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NI</b>		16b. SOCIAL SECURITY NO. <b>216-10-3962</b>		17. INFORMANT ADDRESS <b>ERNESTINE EDWARDS - 1200 SNOWDEN PLACE</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4100 IMMEDIATE CAUSE (a) Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Ischemic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>1978</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>(1) Degenerative Arthritis (2) Paradoxical (3) Left Anterior Hemiblock</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>1-19, 1971</b> to <b>10-18, 1983</b> , that (I) (we) lost saw the deceased alive on <b>10-18, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Alan R. Gair MD</b>		DEGREE		22c. DATE SIGNED <b>11/25/83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALAN R. Gair MD</b>		22e. ADDRESS <b>11700 Old Columbia Pike, Silver Spring MD</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 28, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dr. Mark's Church Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring MD</b>
24. FUNERAL DIRECTOR NAME <b>Tukona Funeral Home, J. G. Walters</b>		ADDRESS <b>254 Carroll St NW DC</b>		25a. DATE RECD. BY REGISTRAR <b>NOV 28 1983</b>		25b. REGISTRAR'S SIGNATURE <b>J. G. Walters</b>

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Howard Alan Jones</b>			2a. DATE OF DEATH MONTH <b>11</b> / DAY <b>11</b> / YEAR <b>83</b>			2b. HOUR <b>355/A M</b>			
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH <b>3</b> / DAY <b>2</b> / YEAR <b>04</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Chemist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Food &amp; Drug</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Takoma Park</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>8508 Flower Avenue 20912</b>	
14. FATHER'S NAME FIRST <b>Howard</b> MIDDLE <b>Linden</b> LAST <b>Jones</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Laura</b> MIDDLE <b>McEachren</b> LAST <b>McEachren</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>017-26-7538</b>		17. INFORMANT ADDRESS <b>Mary Lynch Jones Wife Same as 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4100</b> IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ACUTE MYOCARDIAL INFARCTION PLUS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>AORTIC STENOSIS</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 WK</b> <b>LONG TERM</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>PNEUMONITIS</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <b>JAN 19 75</b> to <b>NOV 11 19 83</b> , that (I) (we) lost saw the deceased alive on <b>NOV 10 19 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE <b>Morrill C. Quinnam Jr.</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-11-83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MORRILL C. QUINNAM JR. M.D.</b>				22e. ADDRESS <b>11120 NEW HAMPSHIRE AVE. SILVER SPRING, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 14, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Mont. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b> ADDRESS <b>500 University Blvd., W. Silver Spring, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 17 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Lohr</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

3 0 6 4 8

1. DECEASED NAME (TYPE OR PRINT) Mylon White Jones			2a. DATE OF DEATH MONTH DAY YEAR 11 9 83			2b. HOUR 7:53 P.M.	
3. SEX male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 12 26 19		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Takoma Park Washington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Adventist Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Owner		12b. KIND OF BUSINESS OR INDUSTRY T.V. Shop	
13a. STATE MD		13b. COUNTY PG		13c. CITY OR TOWN University Park		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST A. MIDDLE A. LAST Jones		15. MOTHER'S MAIDEN NAME FIRST Louise MIDDLE F. LAST White		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes-AAF		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.II 577-42-8598	
17. INFORMANT Mrs. Marian M. Jones		18. ADDRESS Address Same as No# 13c.		19. ZIP CODE - 20782		20. STREET ADDRESS Adelphi Rd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC EPIDERMAL CA OF LUNG 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): CHRONIC OBSTRUCTIVE PULMONARY DISEASE							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from SEPTEMBER 1982 to NOVEMBER 9 1983, that (I) (we) last saw the deceased alive on NOVEMBER 9 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE James G. Brown		DEGREE		22c. DATE SIGNED 11/10/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES A. BROWN (MD)		22e. ADDRESS 625 BELCAST RD. HATTISVILLE MD. 20782		22f. MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 12, 1983		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland	
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Maryland		24b. DATE REC'D. BY REGISTRAR NOV 14 1983		24c. REGISTRAR'S SIGNATURE James G. Brown			



THE ...

7.7. Shop  
Tip ...

197-12-1000 ...

Address ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 30649			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jana Kafka				2a. DATE OF DEATH MONTH DAY YEAR Nov. 7 1983		2b. HOUR PM AM 3:50 PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAR. 28, 1891		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 92	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CZECHOSLOVAKIA		7b. CITIZEN OF WHAT COUNTRY? BRAZIL		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. STATE MD 20816				13b. COUNTY MONT		13c. CITY OR TOWN BETH.	
14. FATHER'S NAME FIRST MIDDLE LAST MAXIMILIAN B. Von Bandrop				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIE P. LOHN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.				16b. SOCIAL SECURITY NO. None			
17. INFORMANT ADDRESS Wash., D.C.				Alexander Kafka. 4201 Cathedral Ave., N.W.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4340 Cerebral Thrombosis with left Hemiplegia DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis, generalized 10 years DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension, essential 10 years PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the undersigned) attended the deceased from Sept 14, 1973, to Nov. 7, 1983, that (I) (we) last saw the deceased alive on Nov. 7, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)							
22b. SIGNATURE DEGREE Joseph J. Wallace M.D.				22c. DATE SIGNED Nov 7, 1983		22d. ADDRESS 5272 River Road Bethesda, Md. 20816	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 11/8/1983		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crem.		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Md	
24. FUNERAL DIRECTOR NAME JOSEPH CRAWLERS SONS INC				25a. DATE REC'D. BY REGISTRAR NOV 14 1983		25b. REGISTRAR'S SIGNATURE Benjamin	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.3  
1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 6 5 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SOPHIE			2a. DATE OF DEATH MONTH DAY YEAR November 28, 1983			2b. HOUR 6:20 PM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 28, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Austria		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Milliner		12b. KIND OF BUSINESS OR INDUSTRY Hats		
13a. STATE Maryland					13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Jacob Glassberg					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (Unascertainable)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 079-20-4657		17. INFORMANT Melvin Kahn		18. ADDRESS 1599 West 10th Street Brooklyn, New York				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360 Cerebral Vascular accident DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 19 73 to Nov. 28 19 83, that (I) (we) last saw the deceased alive on Nov 28 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE John J. Merendino, M. D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS 11620 Kemp Mill Road, Silver Spring, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/30/1983		23c. NAME OF CEMETERY OR CREMATORY Beth David Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Elmont, New York		
24. FUNERAL DIRECTOR NAME Donald M. Stein Hebrew Memorial F. H. S.						25. DATE REC'D. BY REGISTRAR DEC 2 1983				
232 Carroll Street, N. W. Washington, D. C. John J. Merendino										

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11/11/11

DEC 3 1903



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 6 5 1

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ROSE</b> <b>Kalb</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11-1-83</b>				2b. HOUR <b>1:29 A.M.</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 26 07</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Russia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retail</b>	
13a. STATE <b>Mass.</b>				13b. COUNTY <b>Middlesex</b>		13c. CITY OR TOWN <b>Medford</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Beryl Silver</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sonya Unknown</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT <b>Susan Reomer</b>		ADDRESS <b>1421 Highland Dr., SS., Md.</b>		21910	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary artery disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Myocardial infarction</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (10)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>OCT. 29</b> , 19 <b>83</b> , to <b>NOV. 1</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>NOV. 1</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Albert H. Grollman, MD</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/1/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALBERT H. GROLLMAN MD</b>						22e. ADDRESS <b>1106 SILKING ST. SILVER SPRING, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11-2-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Lebanon Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Adelphi, Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Ives-Pearson Funeral Homes</b> Falls Church, Va. 22046						25a. DATE REC'D. BY REGISTRAR <b>NOV 18 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Grollman</b>	

RECEIVED  
U. S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D. C.

TO THE SECRETARY OF AGRICULTURE  
WASHINGTON, D. C.  
FROM THE DIRECTOR OF THE BUREAU OF PLANT INDUSTRY  
SUBJECT: [Illegible]

100% COIL D  
[Illegible]

NOV 18 1908

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carboncopers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

3 0 6 5 2

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		11-3-83		12:48 PM	
2. SEX		3. RACE		4. DATE OF BIRTH		5. AGE (IN YEARS LAST BIRTHDAY)	
Female		White		JANUARY 1, 1888		95 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
New York		USA				MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Rockville		Hebrew Home of Greater Washington		SEAMSTRESS		Trimmings	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
		MARYLAND		MONTGOMERY		ROCKVILLE	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
UNKNOWN		UNKNOWN		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6121 MONTROSE ROAD 20852	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2901 DUE TO, OR AS A CONSEQUENCE OF (b) SENILE DEMENTIA OF ALZHEIMER'S TYPE DUE TO, OR AS A CONSEQUENCE OF (c) 5 DAYS	
No		109-10-4987		SON-IN-LAW			
				ELY WAGNER, 30001 VEAZEY TERR., N.W., WASH., D.C.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 110							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/19/1973 to 11/3/1983, that (I) (we) lost saw the deceased alive on 11/3/1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
D.D. PATEL		M.D.				11/3/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
D.D. PATEL		6121 MONTROSE RD, ROCKVILLE, MD.		CREMATION		11/4/83	
24. FUNERAL DIRECTOR NAME		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION CITY OR TOWN COUNTY		24e. DATE REC'D. BY REGISTRAR	
RICHARD RAPP, INC		CEDAR HILL CREMATORY		SUITLAND PG.		MD.	
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE REC'D. BY REGISTRAR		25d. REGISTRAR'S SIGNATURE	
NOV 8 1983		J. J. Connel					

STATE OF TEXAS

COUNTY OF DALLAS

COMMISSIONERS

THE STATE OF TEXAS

COUNTY OF DALLAS

COMMISSIONERS

THE STATE OF TEXAS

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STATE OF TEXAS

COUNTY OF DALLAS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				3 0 6 5 3	
1. FOR STATE REGISTRAR		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Phebe Brooks Kiger</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>4</b> YEAR <b>83</b>		2b. HOUR <b>11:54</b> AM
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>Jan.</b> DAY <b>26</b> YEAR <b>1889</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>94</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Chevy Chase</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bethesda Nursing &amp; Retirement Ctr.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 20816 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Bethesda</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST <b>George</b> MIDDLE <b>W.</b> LAST <b>Brooks</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Georgie</b> MIDDLE <b>--</b> LAST <b>Earl</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>578-03-4985</b>		17. INFORMANT ADDRESS <b>Alvin B. Kiger, Same address as #13.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4100</b> IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Atherosclerosis of Coronary Vessels</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 days</b> <b>30 days</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NO! WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 3/83</b> to <b>Nov 4/83</b> , that (I) (we) lost saw the deceased alive on <b>Nov 3/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Thomas N. Carter</b>		22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <b>11/7/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thomas N. Carter, M/D</b>		22e. ADDRESS <b>5530 Wisc. Ave. Ch.Ch. Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/8/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington, Virginia</b>		24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons, Inc.</b> ADDRESS <b>5130 Wisconsin Ave., NW, Washington, D.C. 20016</b>			
25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. G... ..</b>			

100-443887-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				30654			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>VESTA E. KILEY</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11 23 83</b>		2b. HOUR <b>12:45 AM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 1 03</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Illinois</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery Co.</b> MD.	
10. CITY OR TOWN OF DEATH <b>Gaithersburg Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Herman Wilson Health Care Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Office Worker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Gov't</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Gaithersburg</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Francis Kiley</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Minerva Maloney</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>577-60-3463</b>	
17. INFORMANT <b>Mrs. George Kiley</b>		ADDRESS <b>Louden, Tenn. 37774</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pancreatic adenocarcinoma</b> 1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF _____ DUE TO, OR AS A CONSEQUENCE OF _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): _____	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>July 10, 1983</b> to <b>Nov 23, 1983</b> , that (1) (we) last saw the deceased alive on <b>Nov 18, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (I) (did) (did not) view the body after death.							
22b. SIGNATURE <b>James R. Moore Jr.</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>11-23-83</b>	
22d. PHYSICIAN'S NAME (IF OTHER)				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS <b>207 Brookes Ave Gaithersburg Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>11/23/83</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>				ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 29 1983</b>	
				25b. REGISTRAR'S SIGNATURE <b>John J. Lister</b>			

Date, Md.

Anatomy Board

Remove 11/2/53



John Francis Kiley Mary Minerva  
577-60-3423 Mrs. George Kiley Rt. 2, Box 36  
London, Tenn. 37714  
Maloney

501 Russell Ave. 20877

Office Worker Gov't

Illinois U.S.A.

White

80 03



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										30655	
FOR 1- STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>BRUCE A KING</b>						2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY YEAR <b>11 27 1983</b>		2b. HOUR <b>00:11</b>			
3. SEX <b>M</b>		4. RACE <b>CAUC</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 6 26 57</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.			
10. CITY OR TOWN OF DEATH <b>Rockville</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SHADY GROVE ADVENTIST HOSP</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Insurance Agent</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>						13b. COUNTY <b>Rockville</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. STREET ADDRESS <b>Box 338</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Chalmer King</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ina D. Fruth</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b> (IF YES, GIVE WAR OR DATES) <b>WWII</b>			
16b. SOCIAL SECURITY NO. <b>272-22-1028</b>				17. INFORMANT <b>Sue E. King</b>				ADDRESS <b>Rt. 3 Box 338 Rogersville, Ala. 35652</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4100 IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>YRS</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Acute</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>NOON 11 26 1983</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Collapsed AT Home</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) <b>Home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>12048 WINDING CREEKWAY Greenbelt MONT MD</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTING SIGNATURE <b>Francis C Mayle</b>				TITLE (SPECIFY) <b>MD</b>				MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT) <b>Francis C Mayle</b>				ADDRESS <b>5200 Wisconsin Ave Bethesda MD</b>				DATE SIGNED <b>11/27/83</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>11/30/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sand Ridge Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bascom, Ohio</b>	
24. FUNERAL DIRECTOR <b>Turner-Engle Funeral Home</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC - 2 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>			
NAME <b>135 N. Wash. Tiffin, Ohio 44883</b>											



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30656

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Loie Manford KING</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 28, 1983</b>		2b. HOUR <b>11:55a M</b>	
3. SEX <b>Female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 18, 1904</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <b>79</b>		
10. CITY OR TOWN OF DEATH <b>SilverSpring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hosp., SilverSpring.</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STREET ADDRESS <b>2320 Arthur Avenue 20902</b>			13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jacob Gearhart</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clara Zimmerman</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>577-03-5108</b>		17. INFORMANT ADDRESS <b>Wyvon W. King Husband Same as 13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pneumonia</b> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Heart Disease</b> 592 DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cerebrovascular Accident</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <b>11/18</b> 19 <b>82</b> to <b>11/28</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>11/28</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Myron L. Lenkin MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/28/83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MYRON L. LENKIN</b>		22e. ADDRESS <b>2309 Shorefield Rd Wheaton, MD</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec. 1, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery Silver Spring Mont. Md.</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR NAME ADDRESS <b>Francis J. Collins</b> <b>500 University Blvd., W. Silver Spring, Md.</b>				
25a. DATE REC'D. BY REGISTRAR <b>DEC 2 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>				

BP

DATE OF BIRTH  
PLACE OF BIRTH  
DATE OF DEATH

November 20, 1922

Montgomery  
13  
1922

Montgomery, Alabama

Montgomery, Alabama



1922

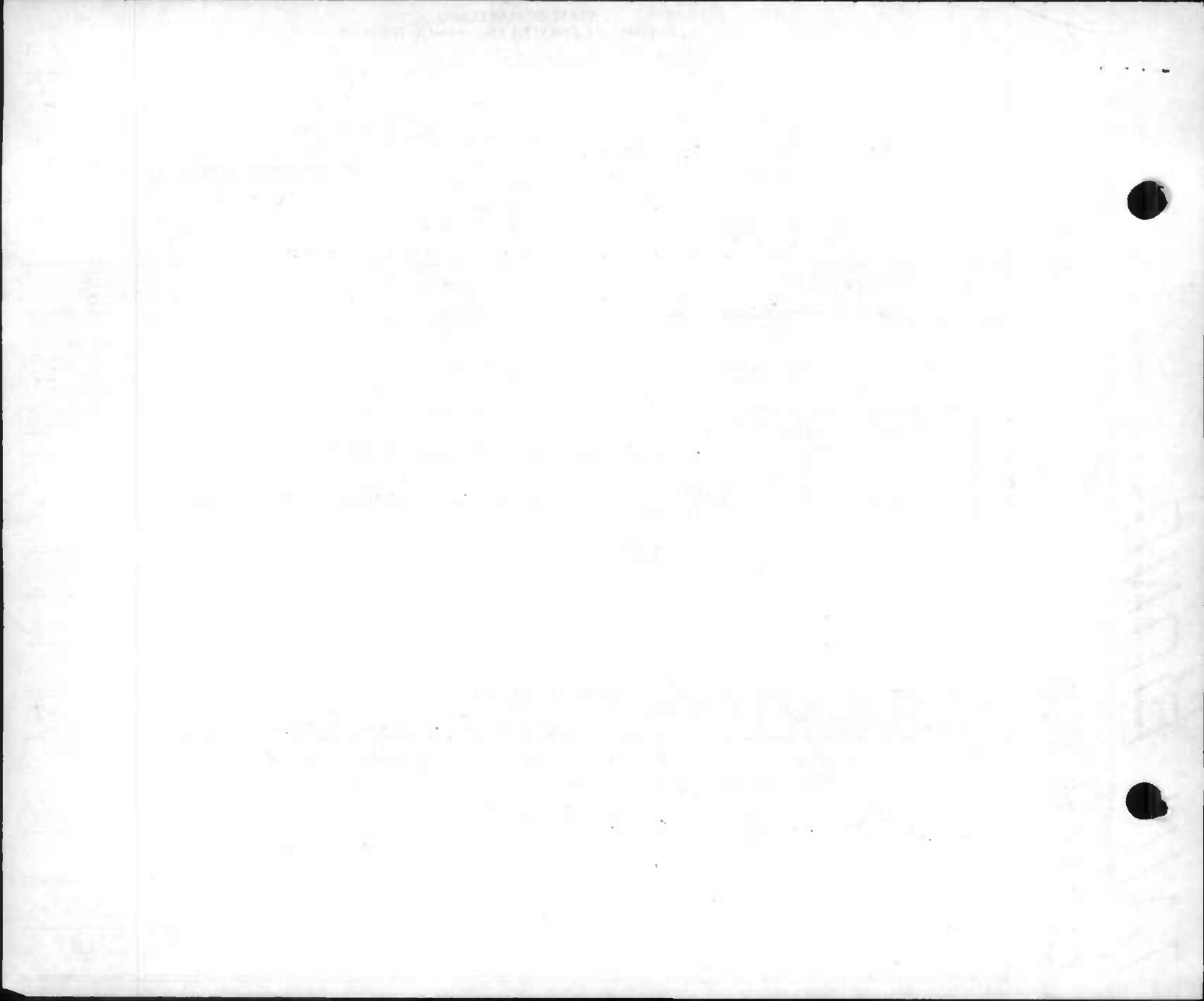
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30651

REG. NO.

1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT)		2b. DATE KNOWN OF DEATH ESTIMATED									
Dorothy Klugman		11 21 1983 A M									
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	7. IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD				2d. HOUR	
Female	Cauc.	June 25, 1899	84 YRS.			11 21 1983				6 40 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Russia		United States				Montgomery County MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Rockville		10401 Grosvenor Place				Homemaker		Home			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Montgomery		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		#1128 20852 10401 Grosvenor Place			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Isreal Marion				Ida Not available							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		17. ADDRESS			
No				051 30 8889		Daughter		10401 Grosvenor Pl. Rockville, Md #1601			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(b) <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				P.M. 11 21 1983		Found AT Home					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION					
						10401 GROSVENOR PL Rockville Mont MD					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE: <u>Francis C. Mayle</u> M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 11/22/83											
EXAMINER'S NAME (TYPE OR PRINT) Francis C. Mayle, M.D. ADDRESS 8200 Wisconsin Avenue Bethesda, Maryland 20814											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Cremation		Nov. 22, 1983		Metropolitan		Crematory Alexandria, Virginia					
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND											
25a. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE					
NOV 23 1983						<u>John J. Gahring</u>					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for an autopsy.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

1- FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				3 0 6 5 8		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Daphne Carson Knight</i>						2a. DATE OF DEATH MONTH DAY YEAR <i>Nov. 1, 1983</i>		2b. HOUR <i>6:35 PM</i>	
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>October 17, 1926</i>		6. AGE (IN YEARS (LAST BIRTHDAY)) <i>57</i>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>West Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.			
10. CITY OR TOWN OF DEATH <i>Wheaton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Randolph Hills Nursing Home</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Office Clerk</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Safeway Grocery</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Wheaton</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>3942 Bel Pre Road # 3</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Jesse Lawson</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Edith Suthern</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>234-38-9221</i>		17. INFORMANT <i>Son</i> ADDRESS <i>3708 Randolph Road Wheaton, Md. 20902</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory arrest</i> 3352 } DUE TO, OR AS A CONSEQUENCE OF (b) <i>myocardial infarction</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>11-1-83</i> to <i>Nov 1, 1983</i> , that (I) (we) lost saw the deceased alive on <i>11-1-83</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Donald L. Bucy</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DONALD L. BUCY</i>		22e. ADDRESS <i>809 Veris Mill Rd. Rockville</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Nov. 4, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Rockville Montgomery Md.</i>			
24. FUNERAL DIRECTOR NAME <i>Francis J. Collins</i>				ADDRESS <i>500 University Blvd., W. Silver Spring, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>NOV 14 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>	

MEDICAL CERTIFICATION





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30059

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MAE R. KNIGHTON</b>			2a. DATE OF DEATH MONTH <b>10</b> DAY <b>1</b> YEAR <b>83</b>		2b. HOUR <b>7:10 A.M.</b>
3. SEX <b>FEMALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH <b>6</b> DAY <b>25</b> YEAR <b>01</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY Co., Md.</b>	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>	NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>PRINCE GEORGE</b> 13c. CITY OR TOWN <b>LAUREL</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>7995 ALADDIN DR. #20707</b>
14. FATHER'S NAME FIRST <b>JAMES</b> MIDDLE <b>ROBINSON</b> LAST <b>ALLEN</b>		15. MOTHER'S MAIDEN NAME FIRST <b>CATHERINE</b> MIDDLE <b>ALLEN</b> LAST <b>ALLEN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>218 18 8086</b>		17. INFORMANT ADDRESS <b>CROOM, MD</b> <b>DOROTHY PRINCIPLE 8060 CROOM RD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: <b>4140</b> IMMEDIATE CAUSE (a) <b>Acute pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>10 yrs</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>29m</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>8/8</b> 19 <b>77</b> , to <b>11/1</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>11/1</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Myron L. Lenkin</b>		DEGREE		22c. DATE SIGNED <b>11/1/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MYRON L. LENKIN</b>		22e. ADDRESS <b>2309 SHOREFIELD RD WHEATON, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>11-2-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CREMATORY SUITLAND P.G.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>SUITLAND P.G. MD</b>					
24. FUNERAL DIRECTOR NAME <b>G.P. KALAS 6160 OXON HILL RD. OXON HILL, MD</b> ADDRESS			25a. DATE REC'D. BY REGISTRAR <b>NOV 7 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified of this.

BP

DHMM - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30660

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Joseph S. Kosisky			2a. DATE OF DEATH MONTH DAY YEAR 11 18 83			2b. HOUR 12:25a.m.					
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 11 16 18		6. AGE (IN YEARS LAST BIRTHDAY) 65 years		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. -----			
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		9. CITIZEN OF WHAT COUNTRY? United States		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
12. CITY OR TOWN OF DEATH Silver Spring		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		15. KIND OF BUSINESS OR INDUSTRY DC Welfare Govt.			
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Maryland			16b. COUNTY Montgomery		16c. CITY OR TOWN Silver Spring		16d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		17. STREET ADDRESS 8 Crest Park Ct 20903		
18. FATHER'S NAME FIRST MIDDLE LAST Joseph S. Kosisky			19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Slymcock								
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			21. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 11		22. INFORMANT ADDRESS Audrey S. Kosisky-wife-(same as 13e)						
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) <u>CARDIO - Pulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary AA disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>15 years.</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24RS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>CARCINOMA of urinary Bladder on chemo therapy</u>											
24. DATE OF OPERATION			25. CONDITION FOR WHICH OPERATION WAS PERFORMED			26. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
28. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
31. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			32. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			33. LOCATION STREET		34. CITY OR TOWN COUNTY STATE			
35. I certify that (I) (this hospital) attended the deceased from <u>10/21</u> , 19 <u>83</u> , to <u>11/18</u> , 19 <u>83</u> , that (I/we) last saw the deceased alive on <u>10/11</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I/we) (did) (did not) view the body after death.											
36. SIGNATURE <u>Max S. Sherer MD</u>						37. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		38. DATE SIGNED 11-18-83			
39. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Max Sherer, MD						40. ADDRESS 800 Pershing Drive Silver Spring, MD 20910					
41. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			42. DATE Nov. 21, 1983		43. NAME OF CEMETERY OR CREMATORY Maryland National		44. LOCATION CITY OR TOWN Laurel		45. COUNTY STATE Pr. Georges Md.		
46. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home						47. ADDRESS 11800 N.H. Ave. Silver Spring, Md.		48. DATE RECEIVED BY REGISTRAR NOV 22 1983		49. REGISTRAR'S SIGNATURE <u>John J. [Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30661

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Gertrude (N.M.I.) Kracke</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 1 83</b>		2b. HOUR <b>2:30 P.M.</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 2, 1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>91</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Riverdale</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William McWhirt</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mamie Rutherford</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>578-01-9951</b>	
17. INFORMANT ADDRESS <b>Mr. Charles G. Walter</b>		18. ADDRESS <b>Address same as No# 13e.</b>		19. ADDRESS <b>Address same as No# 13e.</b>		20. ADDRESS <b>Address same as No# 13e.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Cardiac arrest****4100**

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **acute myocardial infarct**

DUE TO, OR AS A CONSEQUENCE OF

(c) **atherosclerotic heart disease**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>83</b> , to <b>Nov 1</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>SUN</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>MARK K LI</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/1/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARK K LI</b>				22e. ADDRESS <b>1721 University Blvd W. Wheaton MD 20902</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 4, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood P.G. Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b>				25. DATE REC'D. BY REGISTRAR <b>NOV 04 1983</b>		26. REGISTRAR'S SIGNATURE <b>John J. Casper</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health department within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 30662	
1. DECEASED NAME (TYPE OR PRINT) Paul A. Krasley					2a. DATE OF DEATH Nov. 8, 1983		2b. HOUR 10:10 a.m.				
3. SEX Male		4. RACE White		5. DATE OF BIRTH May 17, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12020 Ashley Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Electric		12b. KIND OF BUSINESS OR INDUSTRY Chemist			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 12020 Ashley Drive 20852			
14. FATHER'S NAME Albert C. Krasley		15. MOTHER'S MAIDEN NAME Katie Klockner									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT Paul F. Krasley		ADDRESS Box 26537 Baltimore, Md. 21207					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST - Probable Myocardial Infarction</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>3 years</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from <u>2/3/81</u> 19 <u>83</u> to <u>10/14</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive and <u>above the ground</u> (did not see the body after death) on <u>10/14</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated											
22b. SIGNATURE <u>Gary P. Fisher</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/11/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gary P. Fisher				22e. ADDRESS 5530 Wisconsin Ave. Chevy Chase, Md. 20015							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/12/83		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d. LOCATION Rockville, Maryland STATE					
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland 20852				25a. DATE REC'D. BY REGISTRAR NOV 16 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>					



Statement of the Director

of the Federal Bureau of Investigation

Washington, D. C.

1938-1939

Annual Report

1938-1939

Report

of the

Director

to the

Board of Directors

of the Federal Bureau of Investigation

Washington, D. C.

1938-1939

1938-1939

Annual Report of the Director of the Federal Bureau of Investigation, 1938-1939

Statement of the Director of the Federal Bureau of Investigation, 1938-1939

Annual Report of the Director of the Federal Bureau of Investigation, 1938-1939



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

3 0 6 6 3

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
MICHAEL CRISSY KUHN			MONTH DAY YEAR 11 25 83			424 PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	7d. HOUR	
Male	Caucasian	11 15 50	35 YRS.	MONTHS DAYS HOURS MIN.		11 25 19 83	424 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland		U.S.A.		WIDOWED NEVER MARRIED DIVORCED		MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
ROCKVILLE		BERRYVILLE RD ROCKVILLE		Lab Tech. Solar Energy				
13a. STATE			13b. COUNTY			13c. STREET ADDRESS		
Maryland			Montgomery			20874 CRYSTAL ROCK		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
Robert Lee Kuhn			Earline					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT		
Yes Viet Nam			160 38 0504			SueZann McPherson Springfield, Va. 22150		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) ASPHYXIA								ACUTE
DUE TO, OR AS A CONSEQUENCE OF								
(b) HANGING								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
							YES NO	
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
WHILE AT WORK NOT WHILE AT WORK			HOUR A.M. MONTH DAY YEAR P.M. 11 25 19 83			HANGING FROM TREE		
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION		
FOREST			BERRYVILLE RD ROCKVILLE			MONTGOMERY MD.		
22a. I certify that I took charge of the remains described above, held an autopsy, inspection, inquiry, and in my opinion death resulted from: Accidents, Suicide, Homicide, Undetermined manner.								
22a. I certify that I took charge of the remains described above, held an autopsy, inspection, inquiry, and in my opinion death resulted from: Accidents, Suicide, Homicide, Undetermined manner.								
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
FRANCIS C MAYHE J.			M.D. Dist			11/25/83		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			23b. REGISTER'S SIGNATURE		
1331 Rockville Pike Rockville, Maryland 20852			600 Wisconsin Ave Bethesda, MD			John J. Canine		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
Cremation			11-27-83			Cedar Hill Crematory		
23d. LOCATION (CITY OR TOWN)			COUNTY			STATE		
Suitland			Maryland					
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Tyson Wheeler Funeral Home, Inc.			NOV 30 1983			John J. Canine		

2.

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Figure 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 50M 1/B1  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

3 0 6 6 4

1. DECEASED NAME (TYPE OR PRINT)		FIRST Bernice		MIDDLE J.		LAST Kuhns		2a. DATE OF DEATH MONTH DAY YEAR 11/9/83				2b. HOUR 6:15 pm	
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 8 1 1901				6. AGE (IN YEARS LAST BIRTHDAY) 82				IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 630 Muriel Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY home			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 630 Muriel Street 20852					
14. FATHER'S NAME FIRST MIDDLE LAST John F. Jones				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie E. Pence									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 176-09-2463D		17. INFORMANT ADDRESS Sarah Giarratana same as 13c									
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of the lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>9 mo</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <u>Oct 1</u> , 19 <u>83</u> , to <u>Nov 9</u> , 19 <u>83</u> , that (I) (we) saw the deceased alive on <u>Oct 1</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>William H. Killay</u>				DEGREE <u>MD</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>Nov 9 1983</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>William H. Killay</u>				22e. ADDRESS <u>8218 Wisconsin Ave. Bethesda 20814</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 11/14/83		23c. NAME OF CEMETERY OR CREMATORY Franklin Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Franklin, Venango, Pennsylvania			
24. FUNERAL HOME NAME Tyson Wheeler Funeral Home, Inc. ADDRESS 1331 Rockville Pike, Rockville, Md. 20852				25a. DATE REC'D. BY REGISTRAR NOV 16 1983				25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>					



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DHMH - 16 50M 4/B2  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30665

1. DECEASED NAME (TYPE OR PRINT) <b>IRVING KUZMINSKY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 21 1983</b>		2b. HOUR <b>10:30</b> <sup>a</sup> M
3. SEX <b>MALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>NOVEMBER 2 1927</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>	7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b> <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ENGINEER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>ELECTRONIC</b>
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>	13c. CITY OR TOWN <b>CHEVY CHASE</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>4601 NORTH PARK AVENUE</b> <sup>20815</sup>
14. FATHER'S NAME FIRST MIDDLE LAST <b>SIMON ALEXANDER KUZMINSKY</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>IDA BIEBER</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1945-1947</b>		17. INFORMANT ADDRESS <b>JULIETTE KUZMINSKY, 4601 NORTH PARK AVENUE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA OF LUNG</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 17, 1983</b> , to <b>NOVEMBER 21, 1983</b> , that (I) (we) last saw the deceased alive on <b>NOVEMBER 21, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) sew the body after death.					
22b. SIGNATURE <i>Michael D. Canty</i>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>21 Nov 83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MICHAEL D. CANTY, LT, MC, USNR</b>		22e. ADDRESS <b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>11/22/83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Lebanon Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Adelphi; Prince Geo's; Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS</b>		DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE <b>DEC 12 1983</b> <i>John J. Canine</i>			

MEDICAL CERTIFICATION

COPIES OF THIS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

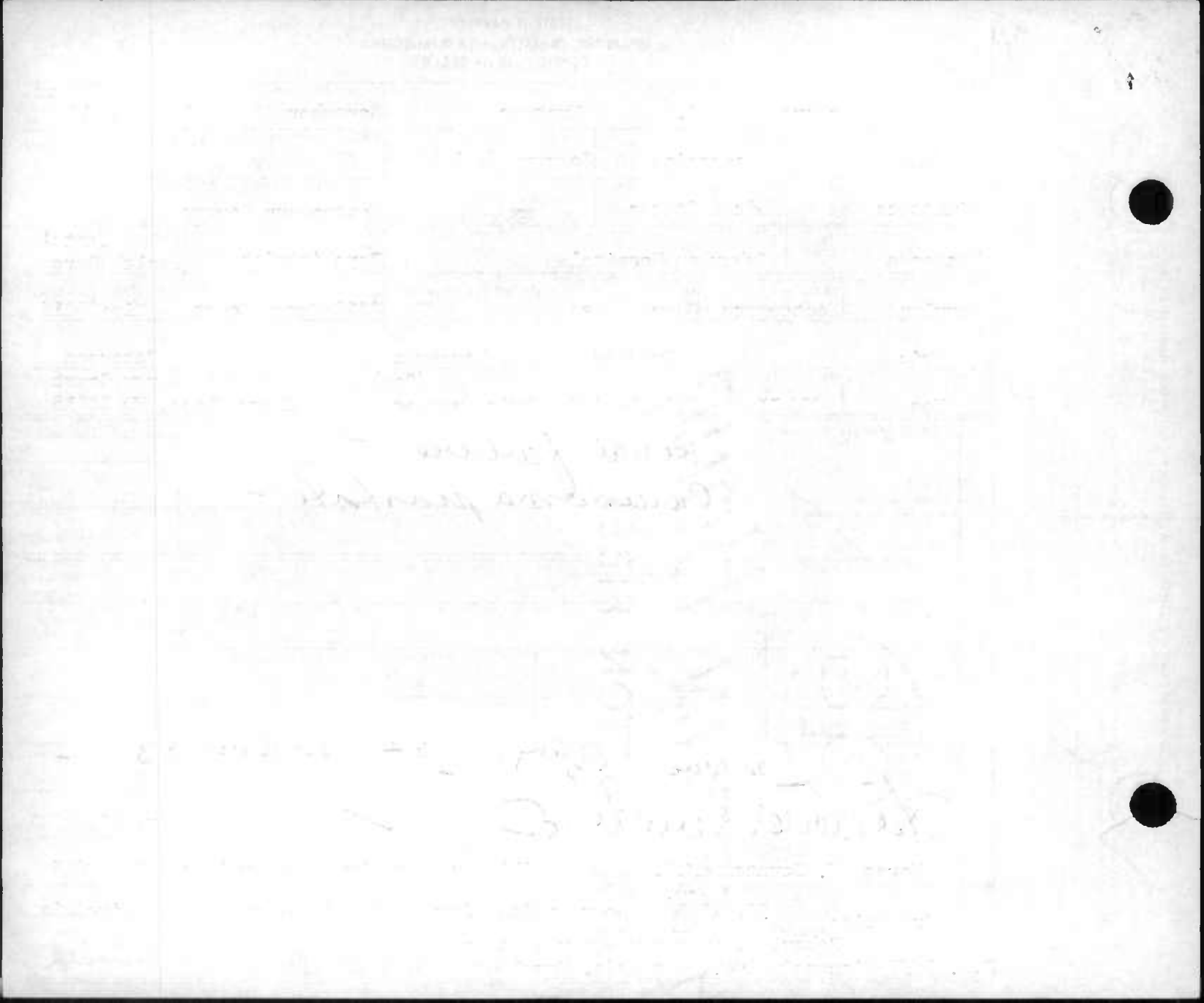
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DHMH - 16 50M 1/81  
(VRA 15, 4)FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30666

1. DECEASED NAME (TYPE OR PRINT) <b>Robert G. Kvarnes</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 20, 1983</b>			2b. HOUR am <b>8:40</b>			
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>January 6, 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Minnesota</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Psychiatrist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Mental Health Care</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Chevy Chase</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>8232 Kerry Court</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Eric Kvarnes</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Peterson</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>704-03-0505</b>		17. INFORMANT (Son) <b>Eric Kvarnes</b>	
16c. ADDRESS <b>8232 Kerry Court</b>		16d. ADDRESS <b>Chevy Chase, MD 20815</b>		18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal failure</b> <b>1850</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma prostate</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>2 Jan 82</b> to <b>20 Nov 83</b> , that (I) (we) lost sight of the deceased alive on <b>20 Nov 83</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.									
22b. SIGNATURE <b>Horace W. Bernton</b>				22c. DATE SIGNED <b>Nov. 23, 1983</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Horace W. Bernton M.D.</b>				22e. ADDRESS <b>4743 Bradley Blvd., Chevy Chase, MD 20815</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Nov. 24, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY <b>Alexandria Virginia</b>			
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connelley</b>			
P.A. 7557 Wisconsin Ave., Bethesda, Maryland									





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Josephine NMI Lack			2a. DATE OF DEATH November 10, 1983		2b. HOUR 10:05 <sup>a</sup>
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR May 9, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Czechoslovakia	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Kensington	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4203 Matthews Lane		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY Pennsylvania Cambria		13b. CITY OR TOWN Ebensburg	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS RD 4 Box 485 (15931)	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Moynak		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Poplick			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 171-32-9120		17. INFORMANT Margaret Lack Betty Orner ADDRESS 4203 Matthews Lane Kensington, MD 20895	

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARCINOMA OF THE STOMACH

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

9 months

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 10</u> , 19 <u>83</u> , to <u>11/10</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>Nov 10</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Richard H. Pollen</u>		DEGREE MD	22c. DATE SIGNED Nov. 10, 1983
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard H. Pollen M.D.		22e. ADDRESS 10400 Connecticut Ave #606, Kensington, MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Nov. 14, 1983	23c. NAME OF CEMETERY OR CREMATORY Lloyds Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Ebensburg, Pennsylvania
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland 20814		25a. DATE REC'D. BY REGISTRAR NOV 14 1983	25b. REGISTRAR'S SIGNATURE <u>John J. Carick</u>



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

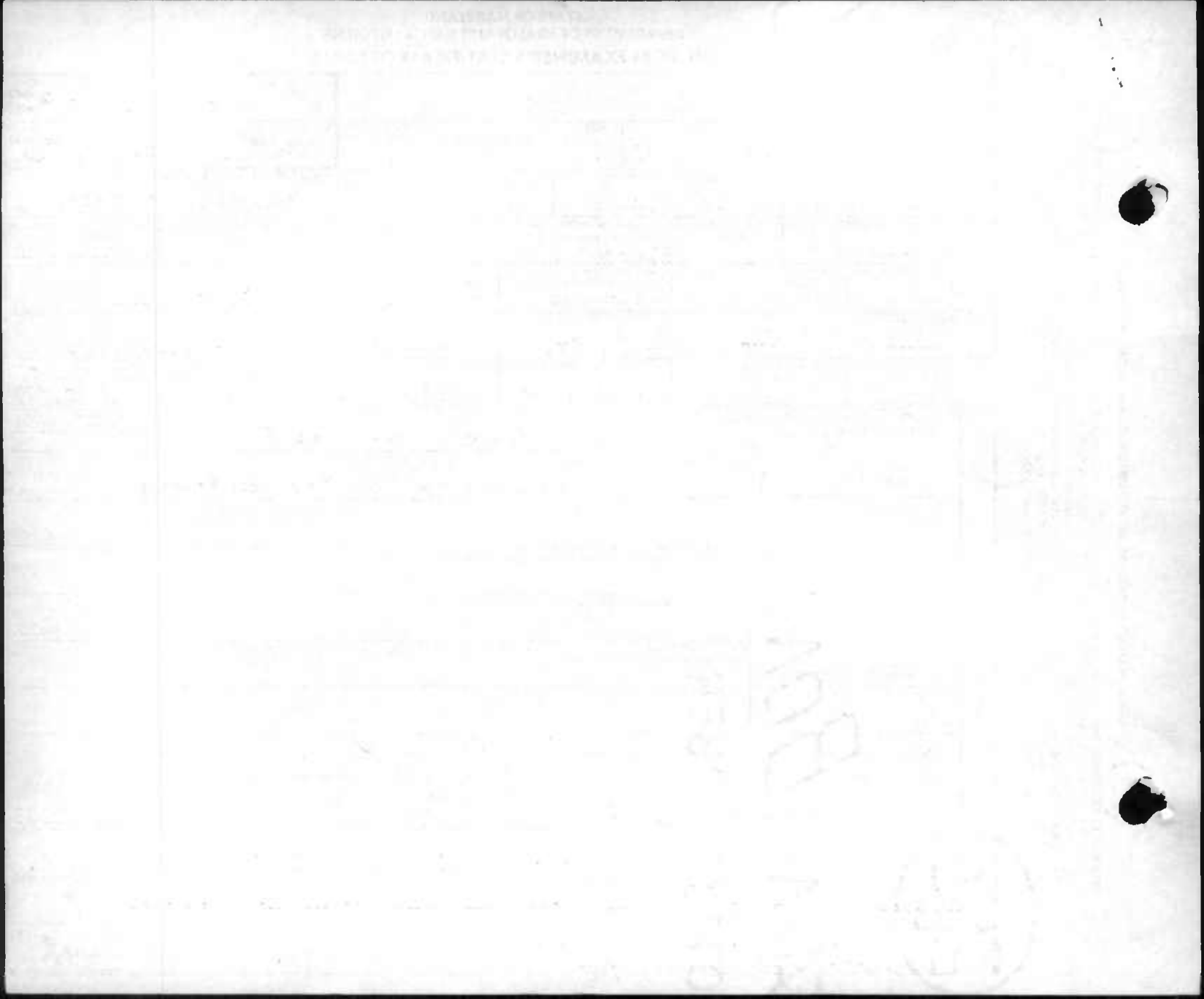
FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

3 0 0 6 8

1. DECEASED NAME (TYPE OR PRINT) William ERS Lamb Jr.			2a. DATE KNOWN OF DEATH ESTI- MATED Nov. 26 19 83			2b. HOUR 2:00 PM		
3. SEX Male	4. RACE Cauca	5. DATE OF BIRTH MONTH DAY YEAR Nov. 5, 1913 70 YRS.	6. AGE (IN YEARS) LAST BIRTHDAY 70 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR Nov. 26 19 83	7d. HOUR 5:00 PM	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD		
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5602 Pollard Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Draftsman		12b. KIND OF BUSINESS OR INDUSTRY Capital Bus	
13a. STATE Maryland				13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. STREET ADDRESS 5602 Pollard Road		
14. FATHER'S NAME FIRST MIDDLE LAST William Ers Lamb, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Besselievre				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 577 16 5138		17. INFORMANT Sister 8001 Temple Hills Rd. Temple Hills, MD Nellie Hancock				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) Cardiac Arrest Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) Coronary arteriosclerosis (c) DUE TO, OR AS A CONSEQUENCE OF								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE John F. Tauber		TITLE (SPECIFY) Deputy		MEDICAL EXAMINER		DATE Nov. 26, 1983		
EXAMINER'S NAME (TYPE OR PRINT) John F. Tauber, M.D.		ADDRESS 8218 Wisconsin Ave. Bethesda, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Nov. 27, 1983		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia		
24. FUNERAL DIRECTOR NAME ROBERT A. BUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND				25a. DATE REC'D. BY REGISTRAR NOV 28 1983		25b. REGISTRAR'S SIGNATURE John J. Canine		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 48 checked, any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lavinia T. LANCASTER			2a. DATE OF DEATH MONTH DAY YEAR Nov. 15, 1983			2b. HOUR 10:00PM				
3. SEX FEMALE		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Jan 11, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sylvan Manor Nursing Home				12a. USUAL OCCUPATION (GIVE MOST OF WORKING LIFE) Building Maintenance		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Derwood		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 17901 Cliffbourne Lane	
14. FATHER'S NAME FIRST MIDDLE LAST John Tapscott			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cornelia A. McCarty							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579 28 3633A			17. INFORMANT ADDRESS John E. Lancaster see # 13 (Son)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA 1561 DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA, Common Bile DUCT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MONTHS "										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from APRIL 19 82 to 11/15/83, that (I) (we) last saw the deceased alive on 11/10/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death.										
22b. SIGNATURE Thos G. Ward M.D.			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 11/15/83				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Thos G. WARD			22f. ADDRESS 6116 Reisterstown Rd, Bethesda, Md 20817							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 18, 1983		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey P.A. Rockville, Maryland					25a. DATE REC'D. BY REGISTRAR NOV 17 1983		25b. REGISTRAR'S SIGNATURE John J. Smith			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30670

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>IRVING L LARISH</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>11 25 83</b>		2b. HOUR <b>1:30 P.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 15 12</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>71</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York City</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sales</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Clothing</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Prince Geo</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Max nmnn Lavarish</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Beckie nmnn Miller</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes WW 11</b>			
16a. SOCIAL SECURITY NO. <b>057-15-3693</b>		17. INFORMANT ADDRESS <b>Sylvia Wathtel 378 Bianco Dr, Oak Grove Village, MD 20783</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4960 IMMEDIATE CAUSE (a) Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>chron obstructive pulmonary disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>myocardial infarction</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>gastrointestinal bleeding</b>							
19a. DATE OF OPERATION <b>non contributory</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>non contributory</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>October 6, 1983</b> , to <b>Nov 25, 1983</b> , that (1) (we) last saw the deceased alive on <b>11/24/83</b> , 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (If (we) (did) (did not) view the body after death).							
22b. SIGNATURE <b>Edith R. Goustein</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/25/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EDITH R GOUSTEIN</b>		22e. ADDRESS <b>9410 OLD GEORGETOWN RD MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-27-1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Beth David Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Elmont, Nassau, Long Is and</b>	
24. FUNERAL DIRECTOR NAME <b>W. W. Chambers Co, Inc, Silver Spring, Md</b>		ADDRESS <b>8655 Georgia Ave</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 30 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>	

BP \_\_\_\_\_

THE UNIVERSITY OF CHICAGO  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and checked.

BP \_\_\_\_\_

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 6 7 1

FOR STATE REGISTRAR			REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) <div style="display: flex; justify-content: space-around;"><span>Mary</span><span>Elizabeth</span><span>Leclair</span></div>			2a. DATE OF DEATH MONTH DAY YEAR <div style="display: flex; justify-content: space-around;"><span>11</span><span>-</span><span>11</span><span>-</span><span>83</span></div>		2b. HOUR 8:00 AM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Mar. 23, 1919	6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1203 Highland Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS (20910) 1203 Highland Drive	
14. FATHER'S NAME FIRST MIDDLE LAST William Joseph Callahan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Dillon			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-30-0257		17. INFORMANT ADDRESS Vincent R. Leclair, same as #13	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <u>11/8</u> 19 <u>83</u> to <u>11/11</u> 19 <u>83</u> , that (2) (we) lost <u>11/8</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) did not view the body after death.					
22b. SIGNATURE <u>Alan S. Kermayer, MD</u>		22c. DATE SIGNED <u>11/11/83</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ALAN I. KERMAIER, MD</u>	
22e. ADDRESS <u>10313 Georgia Ave #308 S.E.</u>		22f. CITY OR TOWN <u>Silver Spring, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 15, 1983		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.	
23d. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland 20814		23e. DATE REC'D. BY REGISTRAR NOV 14 1983		23f. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Tr. Tauber, M.D. released body - Dr. Polen to sign

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) Mildred C Leffingwell			2a. DATE OF DEATH MONTH 11 DAY 5 YEAR 83			2b. HOUR 9:23p M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 27, 1890		6. AGE (IN YEARS LAST BIRTHDAY) 93		7b. HOUR YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Vermont		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Insurance Agent		12b. KIND OF BUSINESS OR INDUSTRY Self Employed	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4011 Spruelli Dr. 20895	
14. FATHER'S NAME FIRST MIDDLE LAST Warren Clark			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jenny Hastings						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS 009-22-7433 A Thomas C. Leffingwell-Brother-(same as 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>4960</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PULMONARY FIBROSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 Hour</u> <u>10 YEARS</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>11-5</u> 19 <u>83</u> to <u>11-5</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>11-5</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <u>Richard H. Polen</u> MD				DEGREE MD				22c. DATE SIGNED 11-6-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD H. POLEN MD				22e. ADDRESS 10400 GHW. AVE. KENSINGTON MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 11-6-1983		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home				11800 N.H. Ave., Sil. Spr. Md.		25a. DATE REC'D. BY REGISTRAR NOV 7 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Givich</u>	

BP

Insurance Agent Self Employed	White	Oct. 27, 1990
4011 Spruill Dr. 20592		
Washington	Montgomery	Washington
Clark	Warren	
002-22-7432 A Thomas G. Jeffingwell-Kocher-(same as 126)	N/A	N/A

Grinell 11-6-1993 Lee's Crematory Washington, D.C.  
1100 N.W. Ave.  
Cal. St. 23.  
Hines/Arnold Funeral Home

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30673

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>FREDERICK Peter LEONARD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 9, 1983</b>		2b. HOUR <b>3:40 AM</b>
3. SEX <b>male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>MARCH 4, 1941</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>42</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>CONNECTICUT</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>WHEATON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3204 Beret Lane</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SYSTEMS ANALYST</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOVT.</b>
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>MONTGOMERY</b>	13c. CITY OR TOWN <b>WHEATON</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>FREDERICK C. LEONARD</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BLANCHE GIROUARD</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>1964 043-32-0355</b>		17. INFORMANT ADDRESS <b>ROSEMARY T. LEONARD WIFE SAME AS 13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>central nervous system leukemia</b> 2050 } DUE TO, OR AS A CONSEQUENCE OF (b) <b>acute myelomonocytic leukemia</b> 5 yrs. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>29 mos.</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) <del>(the deceased)</del> attended the deceased from <b>July</b> 19 <b>81</b> , to <b>Nov 9</b> 19 <b>83</b> , that (I) <del>(was)</del> last saw the deceased alive on <b>Nov 9</b> 19 <b>83</b> , and that in (my) <del>(own)</del> opinion death occurred on the date and hour and from the causes stated above, (I <del>(was)</del> did) <del>(not)</del> view the body after death.					
22b. SIGNATURE <b>Michael B. Stewart M.D.</b>		DEGREE <b>MD.</b>		22c. DATE SIGNED <b>11-9-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MICHAEL B. STEWART</b>		22e. ADDRESS <b>Univ. of Md. Cancer Ctr., 22 S. Greene St., Balto., Md., 21201</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>NOV. 9, 1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>METROPOLITAN CREMATORY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ALEXANDRIA VIRGINIA</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>FRANCIS J. COLLINS 500 UNIVERSITY BLVD., W. SILVER SPRING, MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1983</b>			
		25b. REGISTRAR'S SIGNATURE <b>John J. Gwinn</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral home. Pages 3 and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



KLUTZ-0000

— 1994 —

PROG. INT. CR-108A

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30674

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>THELMA R. LEONARD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 7 83</b>			2b. HOUR <b>5:57 P.M.</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>SEPTEMBER 4, 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>			
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>CHEVY CHASE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>MICHAEL ROSENSTEIN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>PAULINE (UNASCERTAINABLE)</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>163-10-5462A</b>		17. INFORMANT <b>JACK J. LEONARD, 3209 BROOKLAWN TERRACE, MARYLAND</b>				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **LEUKEMIA**

2089

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF

(c) \_\_\_\_\_

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION <b>11/7/83</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>8/3</b> , 19 <b>68</b> , to <b>11/7</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>11/7</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Marie H. GIG, MD</b>		DEGREE		ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN		22c. DATE SIGNED <b>11/7/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARIE H. GIG, MD</b>		22e. ADDRESS <b>3801 Georgia Ave Silver Spring MD</b>					

23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>11/9/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>JUDEAN MEMORIAL GARDENS</b>		23d. LOCATION <b>OLNEY, MONTGOMERY, MARYLAND</b>	
24. DONOR OF ORGANS OR TISSUES <b>DO NOT DONATE</b>				25. DATE REC'D. BY REGISTRAR <b>NOV 10 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Leonard</b>	
26. FUNERAL HOME OR ADDRESS <b>232 CARROLL STREET, N. W., WASHINGTON, D. C.</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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Handwritten signature or text at the bottom left.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

FOR STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Julia C. Leone				2a. DATE OF DEATH MONTH DAY YEAR 14 Nov 83				2b. HOUR 10:40 AM			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Aug. 12 1900		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 74 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3102 Farnborough Court				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Clothing			
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3102 Farnborough Court 20906	
14. FATHER'S NAME FIRST MIDDLE LAST Antonio Campise				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Randazzo							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 185-05-0794		17. INFORMANT ADDRESS Mary Leone Daughter Same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure 4149 DUE TO, OR AS A CONSEQUENCE OF (b) Senile - Ischemic heart disease with complete heart block and congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Weeks Years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes mellitus - insulin requiring Diffuse cerebral atrophy											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from Sept. 19, 1977, to Nov. 19, 83, that (I) (we) last saw the deceased alive on Nov. 19, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Gustavo S. Delaval				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 14 Nov 83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gustavo S. Delaval				22e. ADDRESS Leisure World Medical Center - Silver Spring, Md 20906							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 17, 1983		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Mont. Md.					
24. FUNERAL DIRECTOR NAME Francis J. Collins				ADDRESS 500 University Blvd., W. Silver Spring, Md.				25a. DATE REC'D. BY REGISTRAR NOV 17 1983		25b. REGISTRAR'S SIGNATURE John J. Connel	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove co-bonopoppers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE CECILIA LAST LEWIS			2a. DATE OF DEATH MONTH DAY YEAR 11-5-83		2b. HOUR 7:53 P.M.
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR June 14 1906		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., DC	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash. Adventist Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY -	
13a. STATE Md.			13b. COUNTY Pr. Geo.	13c. CITY OR TOWN Mt. Rainier	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST William H. Vanneman			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary L. Hunt		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -	17. INFORMANT ADDRESS Edward J. Lewis (same as above)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c). PART I. DEATH WAS CAUSED BY: 1749 IMMEDIATE CAUSE (a) <u>pulmonary insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cancer breast</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>(Husband)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr 1 hr					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 85</u> , 19 <u>85</u> , to <u>Nov 83</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>Nov 5</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Martin D. Weltz		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-6-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN D. WELTZ		22e. ADDRESS 7676 New Hampshire Ave Langley Park.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11/9/1983	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.	
24. FUNERAL DIRECTOR NAME Valley's F. H. Inc.		ADDRESS Mt. Rainier, Md.		25a. DATE REC'D. BY REGISTRAR NOV 14 1983	25b. REGISTRAR'S SIGNATURE John J. Gass

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30677

1. DECEASED NAME (TYPE OR PRINT) <b>Robert E. Lewis</b>				2a. DATE OF DEATH MONTH <b>11</b> DAY <b>4</b> YEAR <b>83</b>		2b. HOUR <b>0015</b> M	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH <b>July</b> DAY <b>21</b> YEAR <b>1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CATHOLIC PRIEST</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>GAITHERSBURG</b>	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE <b>11811 CLOPPER ROAD 20878</b>			
14. FATHER'S NAME FIRST <b>B.</b> MIDDLE <b>FRANK</b> LAST <b>LEWIS</b>		15. MOTHER'S MAIDEN NAME FIRST <b>JULIA</b> MIDDLE <b>V.</b> LAST <b>MONAHAN</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>215-12-2342</b>		17. INFORMANT <b>BROTHER</b>		17. ADDRESS <b>722 9th STREET, S.E. WASHINGTON, D.C. 20003</b>			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> 4310 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>subdural hematoma</b> (c) <b>Inter cerebral bleed - med cereb out</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>acute</b> <b>acute</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <b>Infection, Aortic Stenosis, Bradycardia</b>							
19a. DATE OF OPERATION <b>10-21-83</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>10-21-83</b>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 <b>83</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>83 11-4 83</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>10-3-83</b> to <b>11-4-83</b> , that (I) (last) saw the deceased alive on <b>10-3-83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (I) (did not) view the body after death.							
22b. SIGNATURE <b>John S. Smith</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/4/83</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D. BOEY</b>	
22e. ADDRESS <b>80901015 Mill Rd</b>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>					
23b. DATE <b>NOV. 7, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SILVER SPRING MONT. MD.</b>			
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b> ADDRESS <b>500 UNIVERSITY BLVD., W. SILVER SPRING, MD.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Gwinn</b>	

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Defence Force, New Zealand  
The Central Library  
New Zealand  
Correspondence  
New Zealand

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30678

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>SADIE LIEBSTER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Novmeber 30, 1983</b>		2b. HOUR <b>8:45am</b>		
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 12, 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <b>84</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Fairland Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spg.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jacob Liebster</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sophie Baline</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT ADDRESS <b>New York, N.Y.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma Breast, Right</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Senility</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>3 years</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Senility</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from <b>7/13/83</b> to <b>11/30/83</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>11/18/83</b> and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (If I did not view the body after death, I view the body after death.)							
22b. SIGNATURE <b>Thomas G. Ward</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/30/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>THOMAS G. WARD, M.D.</b>				22e. ADDRESS <b>6116 Robinwood Rd.; Bethesda, Md. 20817</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/2/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington Cemetery; Brooklyn, New York</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>DANZANSKY-GOLDBERG MEM. CHPLS.</b>				25. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE <b>DEC 5 1983 John J. Canale</b>			
1170 Rockville Pike; Rockville, Md. 20852							

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 3 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 item only injury, or other traumatic event, the medical certificate must be completed.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

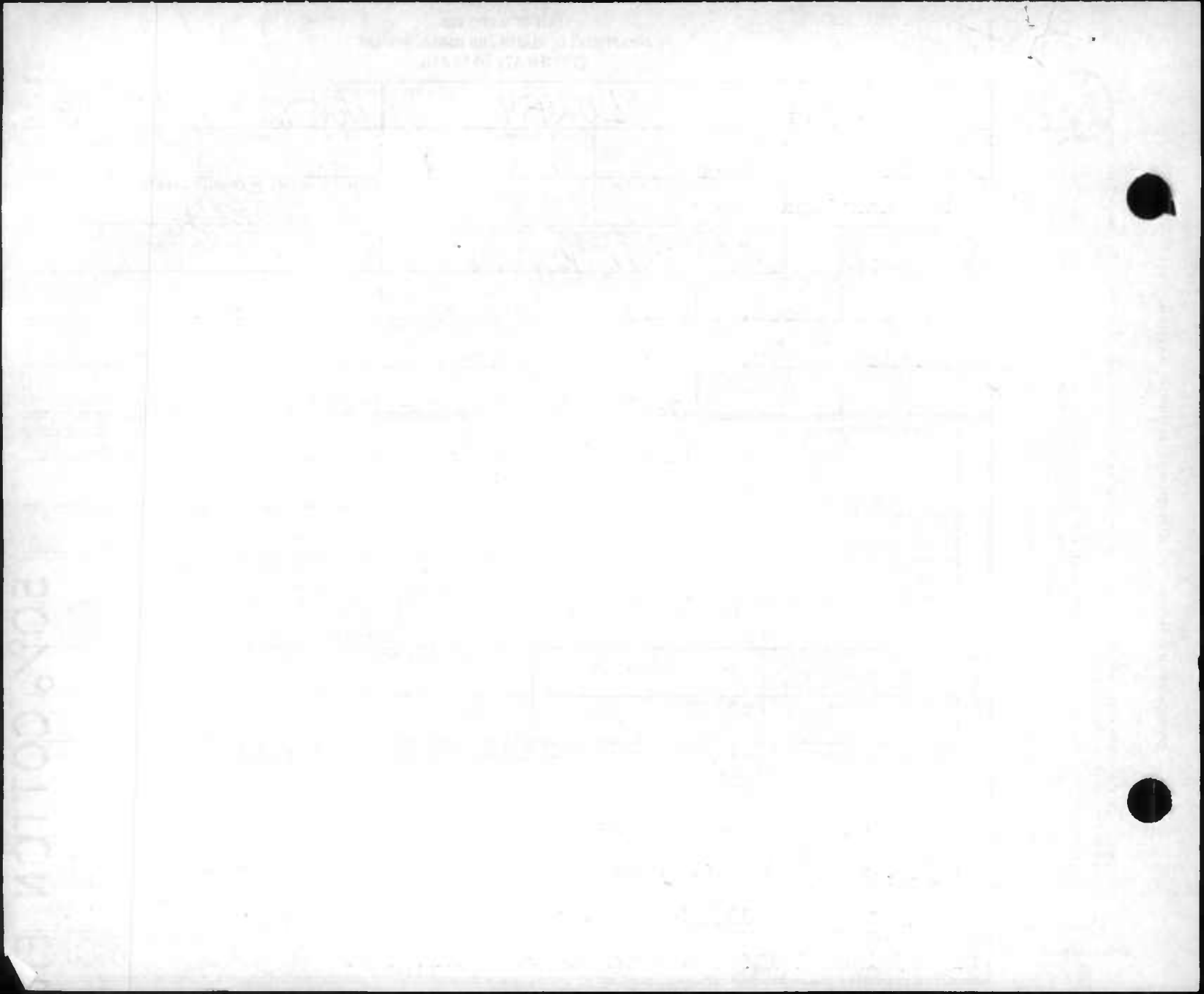
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30679

1. DECEASED NAME (TYPE OR PRINT) <b>ILA LOWRY</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>November 4, 1983</b>		2b. HOUR <b>3:45</b> M	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 22 20</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SINGLE FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Md.</b>	13b. COUNTY <b>Mont.</b>	13c. CITY OR TOWN <b>S.S.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>20903 1932 Kimberly Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Lonnie H. Willard</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lula Lee</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>None</b>		16b. SOCIAL SECURITY NO. <b>579 18 0018</b>		17. INFORMANT ADDRESS <b>June Ford (Daughter) Same as #13E</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>multiple myeloma</b> <b>2030</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Chronic Lung disease, Neuropathy</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1979</b> , 19____, to <b>11/4/83</b> , 19____, that (I) (we) last saw the deceased alive on <b>11/4/83</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Jeremy V. Cooke</b>		DEGREE		22c. DATE SIGNED <b>11/4/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jeremy V. Cooke</b>		22e. ADDRESS <b>10400 Conn. Ave. Kensington</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/7/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>	
23d. LOCATION <b>Brentwood</b>		PG		MD. STATE	
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi</b>		ADDRESS <b>11800 New Hampshire Ave. S. S. Md</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 7 1983</b>	
		25b. REGISTRAR'S SIGNATURE <b>John J. Givich</b>			



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

3 0 6 8 0

1. DECEASED NAME (TYPE OR PRINT) <b>ROSE LYBELL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-25-83</b>			2b. HOUR <b>8:40 A M</b>				
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JULY 1 1890</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>93</b> YRS		7. UNDER 1 YEAR MONTHS DAYS <b>8 40</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.				
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Hebrew Home of Greater Wash.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>					13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ABRAHAM HALPERN</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>REBECCA ITZCOVITZ</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>082-05-2241D</b>			17. INFORMANT ADDRESS <b>Jesse Oroshnik; Son-In-Law; 14800 Marlin Terrace</b>				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4340</b> IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: **SENILE DEMENTIA**

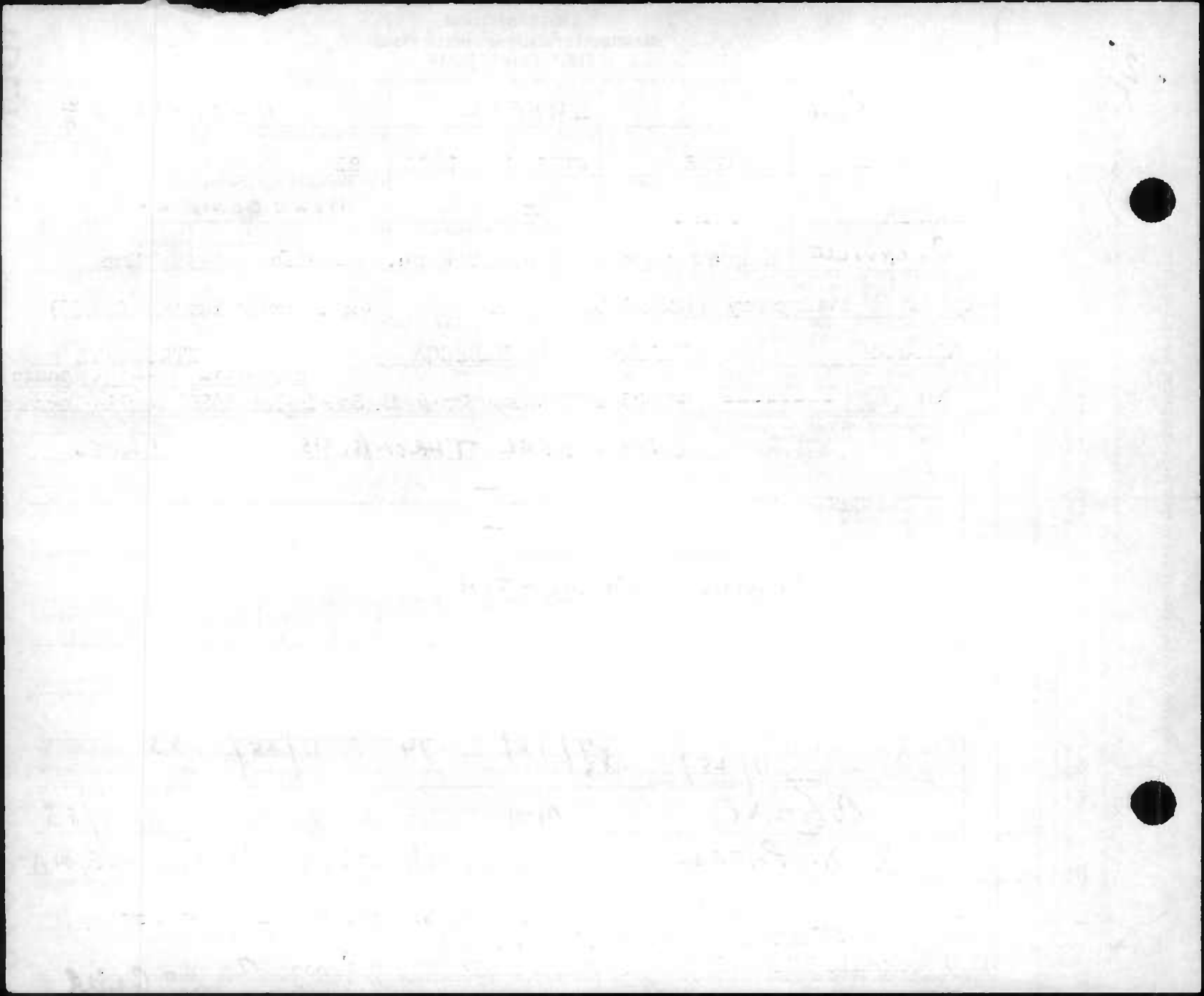
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>7/16/74</b> to <b>11/25/83</b> , that (I) (we) last saw the deceased alive on <b>11/25/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>D. J. PATEL</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/25/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D. J. PATEL</b>				22e. ADDRESS <b>6121 MONTROSE RD, ROCKVILLE, MD.</b>			

23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>11/27/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Park Cemetery; Paramus, New Jersey</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>DANZANSKY-GOLDBERG MEMORIAL CHAPEL</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1983</b>			
1170 Rockville Pike; Rockville, Maryland 20852				25b. REGISTRAR'S SIGNATURE <b>John E. Smith</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked affirmative, show any injury, or other traumatic event, the medical examiner must be notified by name.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				30681			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>LOUISE S. LUTTON</b>				2a. DATE OF DEATH MONTH <b>11</b> DAY <b>11</b> YEAR <b>83</b>			
3. SEX <b>F</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>10</b> DAY <b>23</b> YEAR <b>88</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>95</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>W.H.H.</b>		12a. USUAL OCCUPATION (GIVE WORK FOR LAST 12 MONTHS) <b>Retired State Dept. Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Maryland</b> COUNTY <b>Montgomery</b> CITY OR TOWN <b>Takoma Park</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS <b>1411 - Haucock Ave. 20912</b>	
14. FATHER'S NAME FIRST <b>Frank</b> MIDDLE <b>David</b> LAST <b>Sturgis</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Evelyn</b> MIDDLE <b>Lea</b> LAST <b>Osburne</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>577-28-0377</b>		17. INFORMANT ADDRESS <b>1235 Parkwood Ave. Takoma Park, Md.</b> <b>Mary L. Hubbe (Daughter)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>undue arrest</b> <b>5698</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>asphyxia</b> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Pneumonia</b>							
19a. DATE OF OPERATION <b>11-10-83</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>lobectomy of colon</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the physician) attended the deceased from <b>11-9</b> , 19 <b>83</b> , to <b>11-11</b> , 19 <b>83</b> , that (we) lost saw the deceased alive on <b>11-11</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Michael A. Peskin</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>11-12-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Michael A. Peskin</b>				22e. ADDRESS <b>1109 Spring St Silver Spring, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 15, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington, Va.</b>	
24. FUNERAL DIRECTOR <b>R. J. Hubbe</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV. 15 1983</b>			
25b. REGISTRAR'S SIGNATURE <b>James J. Davis</b>							

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30682

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thomas Francis Lynch			2a. DATE OF DEATH MONTH DAY YEAR NOV 25 1983		2b. HOUR 7 P. M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 2, 1912		
6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		8. AGE UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		10. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
12. CITY OR TOWN OF DEATH Potomac		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11908 Piney Glen Road		14. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.		
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Florida		16b. COUNTY Dade		16c. CITY OR TOWN Miami		
17. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Educator		18. KIND OF BUSINESS OR INDUSTRY High School		19. STREET ADDRESS / ZIP CODE 35161 315 N.E. 111 Street 99999		
20. FATHER'S NAME FIRST MIDDLE LAST Patrick Lynch		21. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Pryor		22. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
23. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		24. SOCIAL SECURITY NO. WWII 109 07 8746		25. INFORMANT wife Lucy T. Lynch Same as item 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1539 IMMEDIATE CAUSE (a) Adenocarcinoma of the Colon (10-82) DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11-83	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from September 22, 19 83, to NOV 25, 19 83, that (I) (we) last saw the deceased alive on NOV 11, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
27b. SIGNATURE Richard W. Holt, M.D.		DEGREE M.D.		27c. DATE SIGNED 11-25-83		
27d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard W. Holt, M.D.		27e. ADDRESS 3800 Reservoir Rd., N.W., Wash, D.C. 20007				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 28, 1983		23c. NAME OF CEMETERY OR CREMATORY St. Ann's Cemetery		
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A. ROCKVILLE, MARYLAND		25a. DATE REC'D. BY REGISTRAR NOV 28 1983		25b. REGISTRAR'S SIGNATURE John J. Carver		
26a. LOCATION CITY OR TOWN Castle Shannon, PA.		26b. COUNTY COUNTY		26c. STATE STATE		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

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1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26



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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>SALL-YUNG Y. MA</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>14</b> YEAR <b>83</b>		2b. HOUR <b>8:44 P.M.</b>
3. SEX <b>Female</b>	4. RACE <b>Oriental</b>	5. DATE OF BIRTH MONTH <b>9</b> DAY <b>3</b> YEAR <b>10</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>China</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Permanent Resident U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Gaithersburg</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Kong-Lam</b> MIDDLE <b>Ma</b> LAST <b>Mui-Ching</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Mui-Ching</b> MIDDLE <b>Liu</b> LAST <b>Liu</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>539-86-8421</b>		17. INFORMANT <b>Mark Eng Son Same as 13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis + Congestive heart failure</b> <b>5939</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>infected dialysis graft site</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>chronic renal insufficiency</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>1981</b>		21f. LOCATION STREET <b>11/14</b> CITY OR TOWN <b>83</b> COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/14</b> 19 <b>83</b> , to <b>11/14</b> 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>11/14</b> 19 <b>83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Joel Gooden</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/15/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOEL GOODEN</b>		22e. ADDRESS <b>4701 RANDOLPH Rd Rockville MD 20852</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 23 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>George Washington</b>	
23d. LOCATION CITY OR TOWN <b>Adelphi</b> COUNTY <b>Pr. Geo.</b> STATE <b>Md.</b>		23e. DATE REC'D. BY REGISTRAR <b>NOV 25 1983</b>			
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b> ADDRESS <b>500 University Blvd., W. Silver Spring, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Collins</b>			

THE UNIVERSITY OF CHICAGO  
LIBRARY

11-10-37

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THE UNIVERSITY OF CHICAGO

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 6 8 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MAUDE B. MAC DOUGALL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-4-83</b>			2b. HOUR <b>8:49</b> M			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 10, 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>74</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD.</b>			
10. CITY OR TOWN OF DEATH <b>Kensington</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Kensington Gardens Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry Deans</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helen Finnigan</b>			13e. STREET ADDRESS <b>5013 Malden Drive</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>056-05-3799</b>		17. INFORMANT ADDRESS <b>William C. MacDougall, same as #13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> 3310 DUE TO, OR AS A CONSEQUENCE OF (b) <b>CORONARY THROMBOSIS</b> 10 hrs DUE TO, OR AS A CONSEQUENCE OF (c) <b>ALZHEIMER'S DISEASE</b> 4 years								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>June 1952</b> , to <b>Nov 4, 1983</b> , that (I) (we) lost saw the deceased alive on <b>10/18</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Frank Y. Jagers Jr. MD</b>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/4/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>FRANK Y. JAGGERS JR.</b>						22e. ADDRESS <b>6000 Executive Blvd Rockville</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>Nov. 7, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Maryland</b>		
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b> <b>5130 Wisconsin Ave., N.W., Washington, D.C.</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV. 14 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canine</b>	

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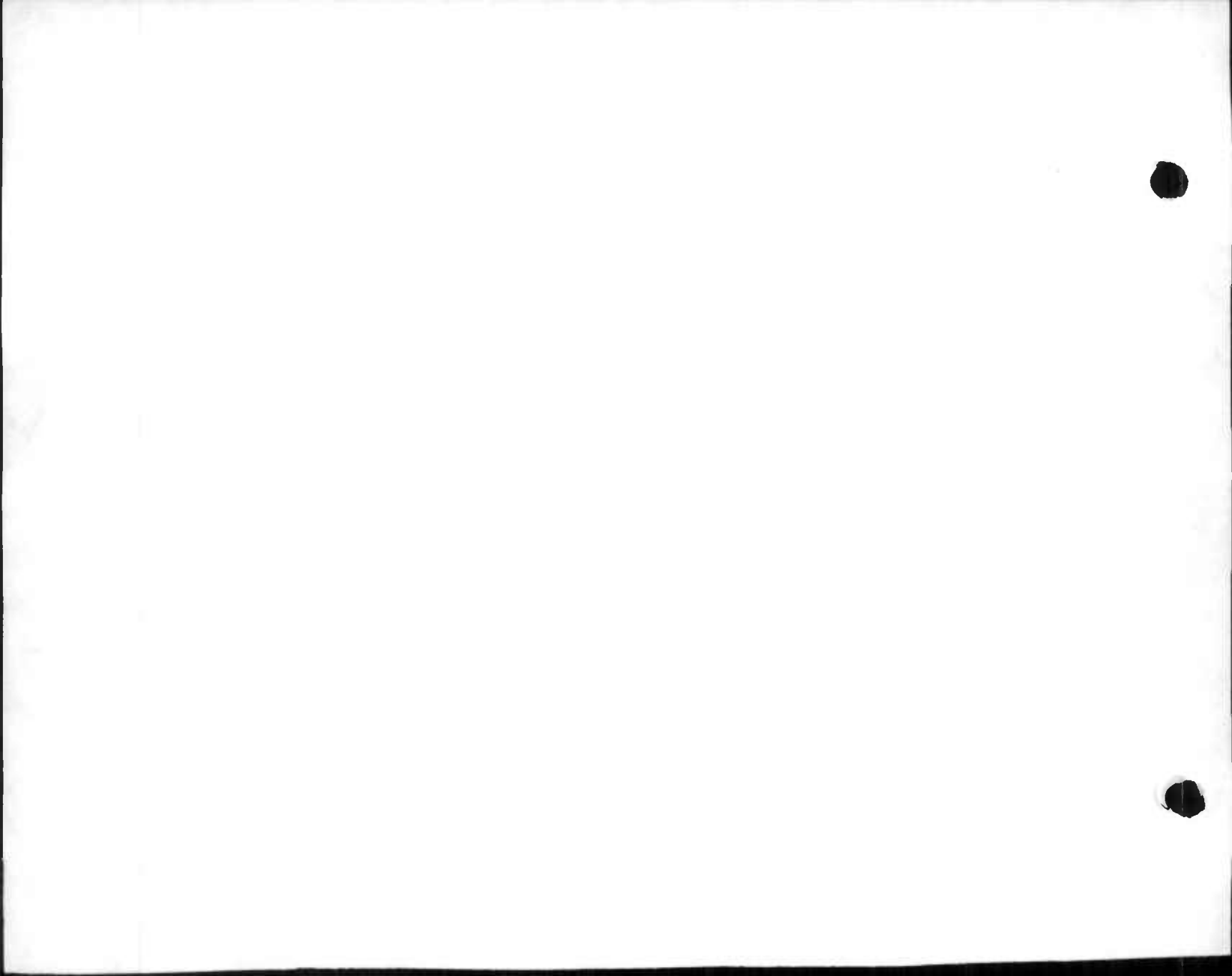
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CERTIFICATE # 30685



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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) <b>CARLO MARCHETTI</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>11/6/83</b>		2b. HOUR <b>9:30 AM</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2/02/18</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.			
10. CITY OR TOWN OF DEATH <b>Silver Spring, Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Self Employed hardware</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>COLLEGE PK.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4711 BERWYN HOUSE RD</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Demetrius Marchetti</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maria Malandrucchio</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII</b>		17. INFORMANT ADDRESS <b>8277 Bark Tree Ct.</b> <b>Carl Marchetti Springfield Virginia</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma</b> <b>1539</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>adenocarcinoma colon</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>2/19/80</b> , 19 <b>83</b> , to <b>11/6</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>11/6</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Hubert J. Alpert</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>6 NOV 83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HUBERT J. ALPERT</b>				22e. ADDRESS <b>8630 FENTON ST SILVER SPRING, MD 20910</b>					
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>November 9, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Maryland Veterans Cemetery Cheltenham, Maryland</b>		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Lee Funeral Home, Inc.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 10 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>			

BP

1980-1981



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30687

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>IRENE C. MARSHALL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-19-83</b>		2b. HOUR <b>6<sup>15</sup> PM</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MARCH 9, 1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS. MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Prince Geor.</b>		13c. CITY OR TOWN <b>College Park</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Carniello</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Amelia Zaccarin</b>		16. STREET ADDRESS <b>6100 Westchester Park Drive</b>		17. HOUSE NUMBER <b>20740</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213 18 3761</b>		17. INFORMANT <b>Cecelia M. Garcia</b>		18. ADDRESS <b>7421 NE Leahy Road New Carrollton, Md. 20784</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

4241

IMMEDIATE CAUSE (a) **CARD. AC ARREST**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) **SEPTIC SHOCK.**

DUE TO, OR AS A CONSEQUENCE OF

(c) **SEVERE THROMBOCYTOPENIA LEUCOPENIA.**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

**SEVERE IMMUNOLOGICAL REACTION - SEVERE AORTIC STENOSIS**

19a. DATE OF OPERATION <b>11/10/83</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>SEVERE CALCIFIC AORTIC STENOSIS</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11/8</b> , 19 <b>83</b> , to <b>11/19</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>11/19</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>S. R. NEINAI, M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SAMIR R. NEINAI, M.D.</b>				22e. ADDRESS <b>10313 GEORGIA AV. SILVER SPRING MD, 20902</b>			

23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>11/22/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood P.G. Maryland</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Funeral Home, P.A.</b> <b>Hyattsville, Maryland</b>				25. DATE REC'D. BY REGISTRAR <b>NOV 23 1983</b>		26. REGISTRAR'S SIGNATURE <b>John J. Casper</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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2000

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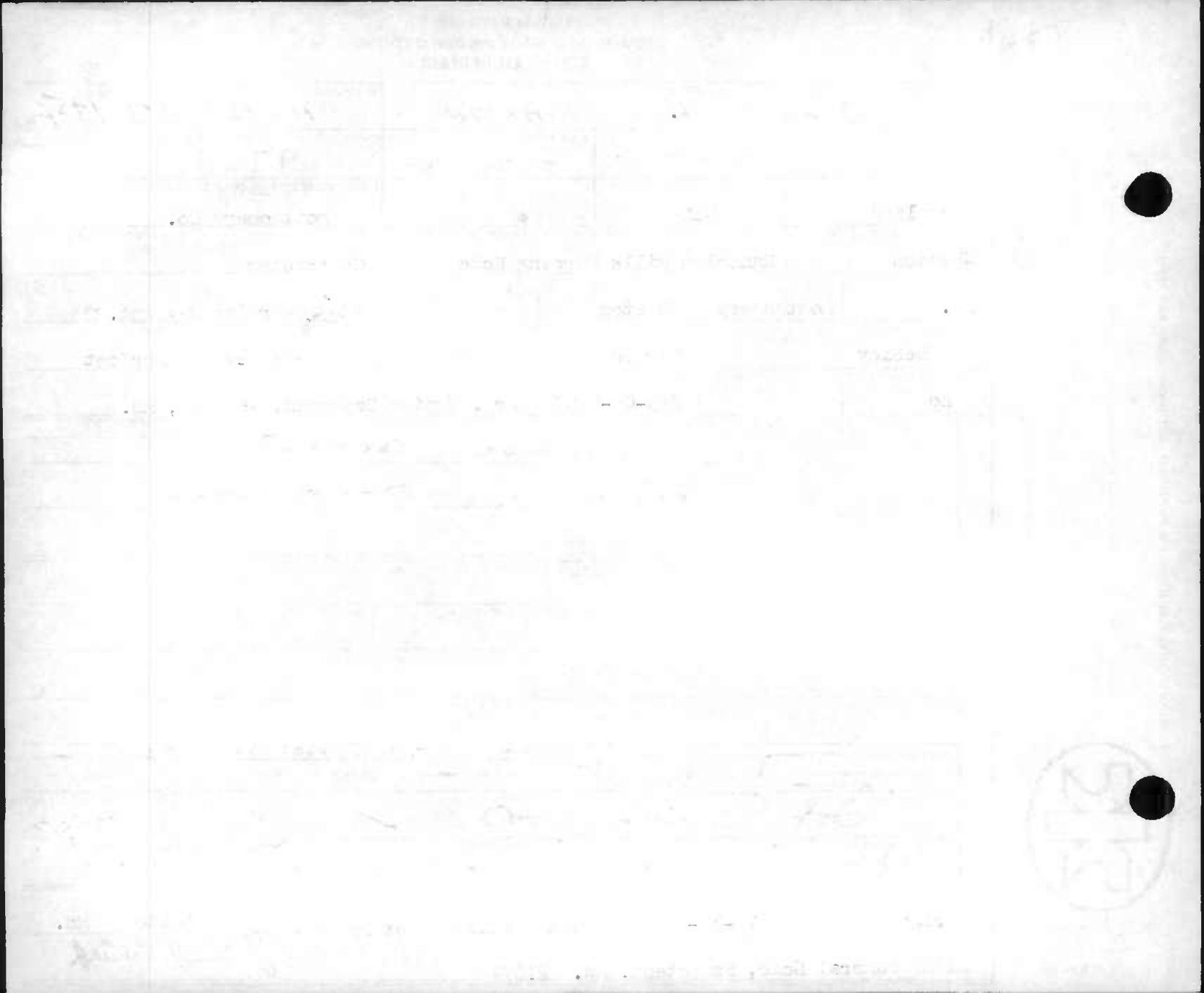
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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. FOR STATE REGISTRAR				20. DATE OF DEATH MONTH DAY YEAR	
1. DECEASED NAME FIRST MIDDLE LAST JOHN W. MARTIN				11-12-1983	
2. SEX M		4. RACE white		2b. HOUR 1:45 PM	
3. AGE (IN YEARS LAST BIRTHDAY) 97 YRS.		5. DATE OF BIRTH MONTH DAY YEAR 5 26 86		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Randolph Hills Nursing Home	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Contractor		12b. KIND OF BUSINESS OR INDUSTRY		13. STREET ADDRESS 2303 Georgian Way Apt. 23	
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 20901		14. FATHER'S NAME FIRST MIDDLE LAST Wesley Martin	
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Frances Morfoot		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 215-05-8063A	
17. INFORMANT ADDRESS Mrs. Eunice Sandeman, Wheaton, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) coronary arteriosclerosis (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (am) (was) attended the deceased from June 19 73, to Nov. 12 19 83, that (I) (am) (was) lost saw the deceased alive on 10-22 19 83, and that in (my) (an) opinion death occurred on the date and hour and from the causes stated above, (I) (am) (did) (not) view the body after death.		22b. SIGNATURE John T. [Signature] DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED 11-12-83		22d. PHYSICIAN'S NAME (TYPE OR PRINT) John T. [Signature]		22e. ADDRESS 8218 Wisconsin Ave.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-15-83		23c. NAME OF CEMETERY OR CREMATORY Forest Baptist Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.		24. FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md. 21074		25. DATE RECEIVED BY REGISTRAR NOV 17 1983	



RELEASED BY DR. ~~XXXXXXXX~~ MAYLE

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Katherine B. Mason			2a. DATE OF DEATH MONTH DAY YEAR November 24, 1983		2b. HOUR 12:30 PM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Nov. 7, 1899	6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Chevy Chase	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5480 Wisconsin Avenue	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Chevy Chase	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS (20815) 5480 Wisconsin Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Percy Bullard			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Richardson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW I		16b. SOCIAL SECURITY NO. 578-62-9113	17. INFORMANT ADDRESS 358 Causeway Dr. NC William B. Mason Wrightsville Beach,		
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cancer of Stomach 1519 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from February 19 83, to Nov. 24 19 83, that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Wesley M. Oler, M.D. DEGREE				22c. DATE SIGNED 11/24/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wesley M. Oler, M.D.				22e. ADDRESS 3301 New Mexico Avenue, N.W. Washington, D.C. 20016	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Nov 28, 1983	23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia	
24. FUNERAL DIRECTOR'S NAME Robert A. Pumphrey Homes, P.A. Bethesda, Maryland 20814				25a. DATE REC'D. BY REGISTRAR NOV 28 1983 25b. REGISTRAR'S SIGNATURE John L. Conner	

BP

THE UNIVERSITY OF MICHIGAN  
LIBRARY  
ANN ARBOR, MICHIGAN



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BP

DHMH - 16 50M 1/81  
(VRA 15, 4)1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MABEL R MATIMORE			2a. DATE OF DEATH MONTH DAY YEAR 11/7/83		2b. HOUR 10:30 AM
3. SEX F	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 03 18 94		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
13a. STATE Md.		13b. COUNTY Montgomery	13c. CITY OR TOWN Gaithersburg	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas - Schaiell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia - Donley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-74-0712B		17. INFORMANT June M. Habershon	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ANEMIA</u> 2898 } DUE TO, OR AS A CONSEQUENCE OF <u>myelofibrosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>year</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>83</u> to <u>11/7/83</u> , that (I) (we) lost saw the deceased alive on above <u>11/7/83</u> (did) (did not) view the body after death and that is (my) (our) opinion death occurred on the date one hour and from the causes stated					
22b. SIGNATURE Thos G. Ward		22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 11/7/83	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 11/8/83		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.		24. FUNERAL DIRECTOR Gartner Sandison F. H. Gaithersburg, Md. 20877			
25a. DATE REC'D. BY REGISTRAR NOV 9 1983		25b. REGISTRAR'S SIGNATURE James G. Smith			

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STATE OF MARYLAND 8 3 3 0 6 9 1  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>DAVID SEATON MAUPIN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 1 1983</b>		2b. HOUR <b>2:00 a</b> M
3. SEX <b>MALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>APRIL 21 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>TENNESSEE</b>	7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. NAVY</b>
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>ANNE ARUNDEL</b>	13c. CITY OR TOWN <b>HARWOOD</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>ROBERT LUTHER MAUPIN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY ELIZABETH RUCKER</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>1917-1949 216-34-6527</b>		17. INFORMANT ADDRESS <b>VENETIA B. MCNEMAR, 10 HARWOOD DRIVE, HARWOOD, MD 20776</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>1950</b> IMMEDIATE CAUSE (a) <b>SQUAMOUS CELL CA OF HEAD AND NECK, METASTATIC</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					
19a. DATE OF OPERATION <b>29</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 24, 1983</b> , to <b>NOVEMBER 1, 1983</b> , that (I) (we) lost saw the deceased alive on <b>NOVEMBER 1, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>J. P. Asher</i>		DEGREE <b>LT, MC, USNR MD</b>		22c. DATE SIGNED <b>1 NOV 1983</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. P. ASHER, LT, MC, USNR</b>		22e. ADDRESS <b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Nov. 4, 1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Annapolis A.A MD</b>	
24. FUNERAL DIRECTOR NAME <b>Taylor Funeral Chapel-Annapolis, MD</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 02 1983</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Carter</i>	

BP

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30692

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JANE S. MAUZY			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 20, 1983			2b. HOUR 5:00 A				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEBRUARY 5, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH CHEVY CHASE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4303 BRADLEY LANE			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TEACHER		12b. KIND OF BUSINESS OR INDUSTRY PUB SCHOOLS			
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN CHEVY CHASE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 4303 BRADLEY LANE 20815	
14. FATHER'S NAME FIRST MIDDLE LAST unknown stover				15. MOTHER'S MAIDEN NAME FIRST MIDDLE JANE McCOUBRIE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-42-9333		17. INFORMANT ADDRESS 4303 BRADLEY LA. BARBRA MAUZY, DAUGHTER, CHEVY CHASE, MD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrhythmia</u> 4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> (c) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hr 4 yr 8 yr										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hypertension, Chronic Renal</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 1977</u> to <u>20 Nov 83</u> , that (I) (we) last saw the deceased alive on <u>14 Oct 83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Eugene P. Libre M.D.</u>			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 20 Nov 83		
22b. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE P. LIBRE M.D.			22b. ADDRESS 18400 Connecticut Ave Bensington, Md. 20815							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 11/21/83		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND PG. MD.		
24. FUNERAL DIRECTOR NAME ADDRESS RICHARD RAPP, INC. 1120 CONN. AVE., N.W. #940, WASH., D.C.			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE NOV 22 1983				

MEDICAL EXAMINER NOTIFIED AND RELEASED

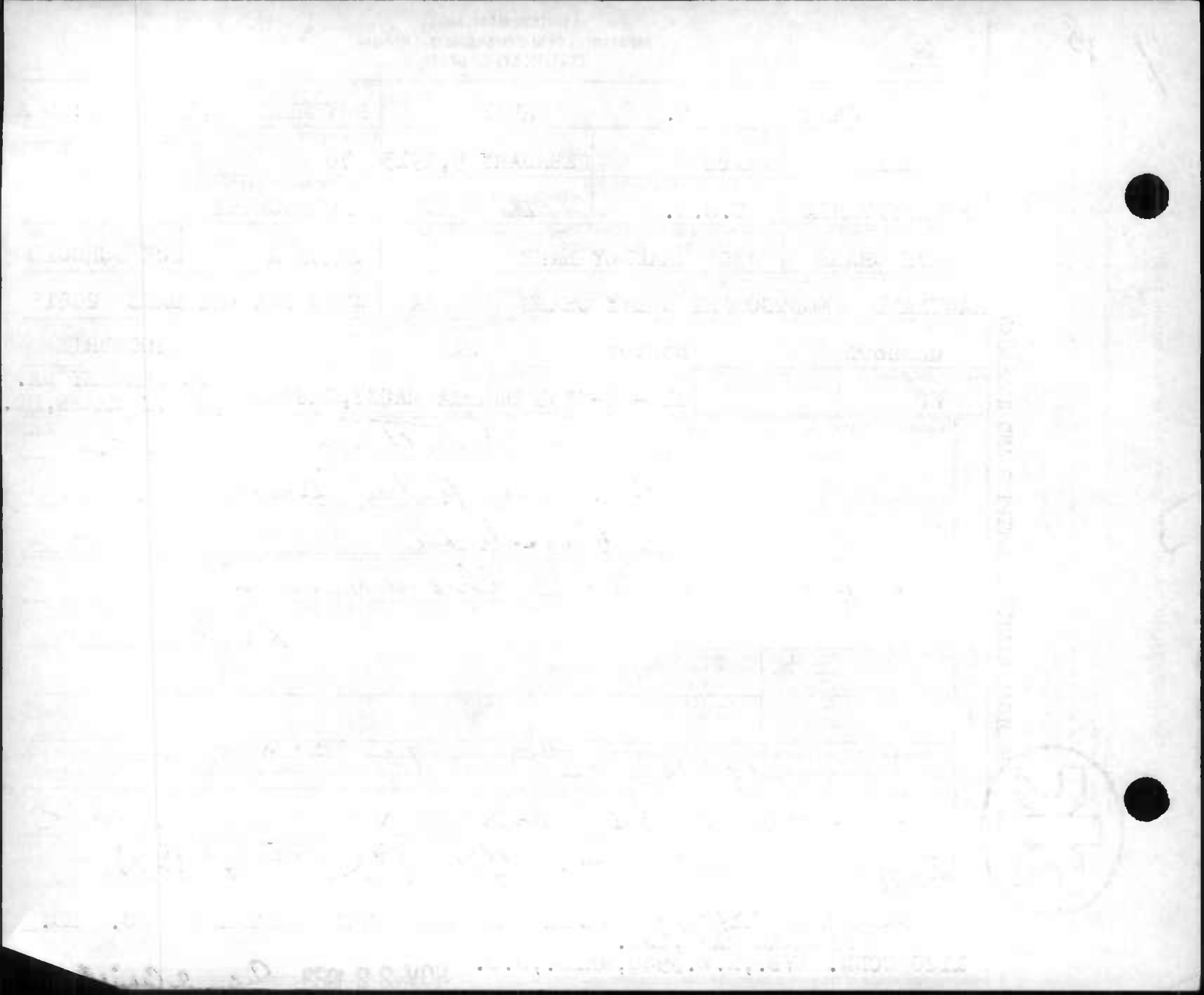
MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



3 0 6 9 3

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Elsie H. Maxfield</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>11-24-83</b>		2b. HOUR 4:11 A-M	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 6, 1908</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Missouri</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery Co.</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>owner</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Welding company</b>		13a. STREET ADDRESS / ZIP CODE <b>10000 Brunswick Ave., 20910</b>	
13b. STATE <b>Maryland</b>		13c. COUNTY <b>Montgomery</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George F. Kagel</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marie Bressmer</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>489-10-0931</b>		17. INFORMANT <b>Daniel Maxfield</b>		ADDRESS <b>2312 Solmar Drive 20904 Silver Spring, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Pyelonephritis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Bilateral Stagnant Calculi</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>5920</b> <b>5+ years</b> <b>5+ years</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Rheumatoid Arthritis</b>					
19a. DATE OF OPERATION <b>11-12-83</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Fracture right hip</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11 9 1983</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>Pathologic Fracture of right hip.</b>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ARM, ETC.) <b>Hospital</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Holy Cross Hospital Silver Spring Montgomery Md.</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>11-24-83</b> to <b>11-24-83</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Morris Perry</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11-24-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Morris Perry</b>		22e. ADDRESS <b>11602 Georgia Ave. Silver Spring, Maryland 20902</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 28 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Michigan Memorial</b>	
24. FUNERAL DIRECTOR NAME <b>ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Flat Rock Michigan</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1983</b>	
				25b. REGISTRAR'S SIGNATURE <b>J. J. Connel</b>	

Small of right hand

Morris Perry

1877

1877

MD

X

1877

1877

11-12-80

Remounted

Anterior

Chronic

Fracture

11-12-80

Remounted

Anterior

Chronic

Fracture

11-12-80

Remounted

Anterior

Chronic

Fracture

11-12-80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
CARL SYLVESTER MCCARTHY				NOVEMBER 21 1983		9:25 a.m.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
MALE	CAUCASIAN	MONTH DAY YEAR		84 YRS		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
INDIANA	UNITED STATES			MONTGOMERY		MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
BETHESDA	NAVAL HOSPITAL		RETIRED Officer		U.S.M.C.		
13a. STATE 20016 13b. COUNTY DISTRICT OF COLUMBIA				13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
TIMOTHY MCCARTHY				MARY ELIZABETH CAMPBELL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
YES		1942-1960		HELEN SWINDLER, 3221 WYNFORD DRIVE, FAIRFAX, VA 22031			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LYMPHOMA 2028 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from OCTOBER 25, 1983, to NOVEMBER 21, 1983, that (I) (we) lost saw the deceased alive on NOVEMBER 21, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. PHYSICIAN'S NAME (TYPE OR PRINT)				22c. DATE SIGNED		22d. ADDRESS	
PETER S. GILL, LT, MC, USNR				22 NOV 83		NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		11/28/1983		Arlington Nat. Cem.		Arlington Virginia	
24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., DC.				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
				NOV 28 1983			

Official

Commission

2000

Commissioner

Commissioner

12/1/1933

1933

Commissioner

12/1/1933



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BP \_\_\_\_\_

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND 8 3 3 0 6 9 5  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Joseph S. McCarthy</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 3 1983</b>			2b. HOUR P M <b>1:20 P M</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 2, 1918</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>OH</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Kensington</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4017 Glenrose St.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Attorney</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Law</b>	
13a. STATE <b>Md. 20895</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Kensington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4017 Glenrose St.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John F. McCarthy</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary SEXTON</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes. WW II</b>		16b. SOCIAL SECURITY NO. <b>293-05-7676</b>		17. INFORMANT ADDRESS <b>Lina P. McCarthy Same as item # 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Malignant Brain Tumor</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>1919</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>Approx 2 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>6/83</b> , 19____, to <b>Present</b> , 19____, that (I) (we) last saw the deceased alive on <b>8/83</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Jeff Jacobson M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11/3/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jeff Jacobson, M.D.</b>				22e. ADDRESS <b>3 Washington Cir. NW Wash., DC 20037</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/5/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate Of Heaven Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring, MD</b>			
24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons, Inc.</b> ADDRESS <b>5130 Wisc. Ave. N.W. Wash., D.C. 20016</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 9 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>			

MEDICAL CERTIFICATION

1952

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• • • *CONFIDENTIAL* • • •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 6 9 6

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Ruth E. McCauley</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-14-83</b>		2b. HOUR <b>1:45 P.M.</b>
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>01 16 02</b>		6. AGE (IN YEARS, LAST BIRTHDAY) <b>81</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Takoma Pk</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Wash. Adventist Hosp</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>	
13a. STATE <b>Md</b>		13b. COUNTY <b>MG</b>		13c. CITY OR TOWN <b>Takoma Pk</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Richard Hanes.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Lowry.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No.</b>		16b. SOCIAL SECURITY NO. <b>578-61-2368</b>		17. INFORMANT ADDRESS <b>Mary E. Miller ( Daughter ) 13 e</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio pulmonary arrest</b> <b>2500</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Overwhelming Sepsis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetic Mellitus</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Multiple Massive cerebral vascular accidents</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11-78</b> , 19____, to <b>11-14-83</b> , 19____, that (I) (we) (lost) saw the deceased alive on <b>11-14-83</b> , 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Charles L Franklin Jr</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11-14-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles L Franklin Jr</b>		22e. ADDRESS <b>11120 New Hampshire Ave SShel 20901</b>			
23a. BURIAL, CREMATION, REMOVAL (PRINT) <b>Burial</b>		23b. DATE <b>Nov. 17, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rockville, Montg. Md</b>		23e. DATE REC'D. BY REGISTRAR <b>NOV 17 1983</b>			
23f. FUNERAL DIRECTOR <b>Takoma Funeral Home, Inc</b>		23g. REGISTRAR'S SIGNATURE <b>John J. Coker</b>			

ADAM/ELIXIR

COPIES

224 Carroll St. N.W. Atlanta, Ga. 30303  
Atlanta General Home, Inc.  
Box 111, 21st St. N.W. Atlanta, Ga. 30303

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30697

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ANGELEE B. McCLAINÉ</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 16 83</b>		2b. HOUR <b>2 AM</b>					
3. SEX <b>F</b>		4. RACE <b>BLK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 5 28</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>55</b>		IF UNDER 1 YEAR IF UNDER 24 HRS.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>GEORGIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>TAKOMA PARK mont. C. MD.</b>				
10. CITY OR TOWN OF DEATH <b>TAKOMA PARK</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASH. ADVENTIST HOSP</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>GOVT. EMP.</b>		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>D. C.</b>			13b. COUNTY <b>WASH.</b>		13c. CITY OR TOWN <b>WASH.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6121 DIX ST. N. E. 99999</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>EZEKIEL BEDNEY</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>NOT STATED</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>258 32 9910</b>		17. INFORMANT ADDRESS <b>CLEVELAND McCLAINÉ 6121 DIX ST., N. E.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>1519 IMMEDIATE CAUSE (a) METASTATIC CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARCINOMA OF STOMACH</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>10 months</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a. DATE OF OPERATION <b>9/16/83</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Intestinal Obstruction secondary to recurrent cancer</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the hospital) attended the deceased from <b>9/11</b> , 19 <b>83</b> , to <b>11/16</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>11/15</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (we did not) view the body after death.										
22b. SIGNATURE <b>Albert E. Rolle, M.D.</b>				DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/16/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALBERT E. ROLLE, M.D.</b>				22e. ADDRESS <b>KAISER/GEORGETOWN CAP 601 Edgewood St. N.E. WDC 20017 (202) 636-9500</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11-21-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FR. LINCOLN CEM</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood Md.</b>				
24. FUNERAL DIRECTOR NAME <b>W. ATSON F.H.</b>				24b. ADDRESS <b>3435 14TH ST. NW</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 17 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canfield</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

OFFICE OF THE  
ATTORNEY GENERAL  
STATE OF TEXAS



WILLIAM F. SMITH, JR.  
ATTORNEY AT LAW  
DALLAS, TEXAS

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE EXAMINER'S OFFICE. TO HEALTH DEPARTMENT: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE EXAMINER'S OFFICE. TO BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

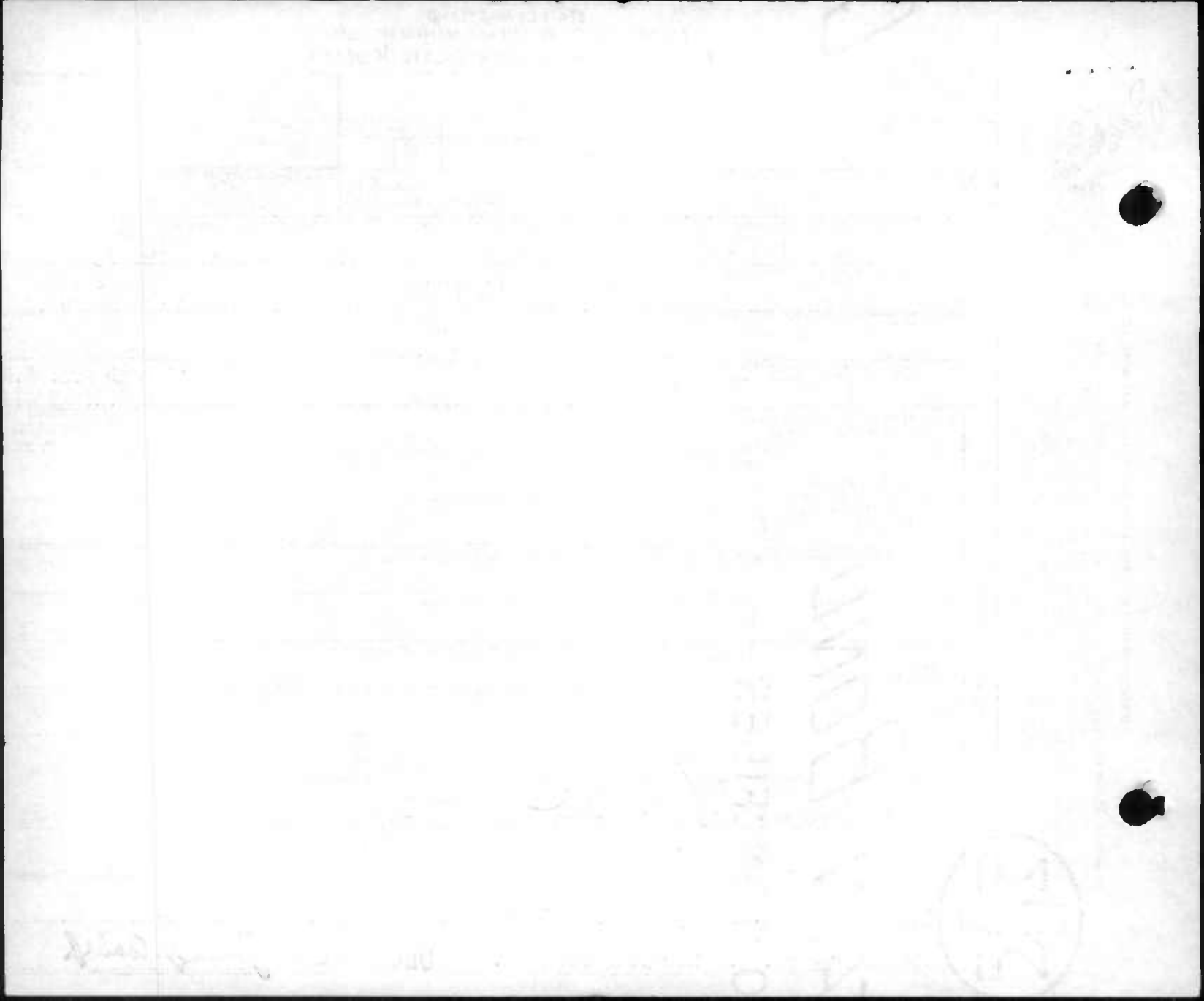
BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE REGISTRAR		FOR		3 0 6 9 8	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE	
Dorothy		McConnell			
2a. DATE OF DEATH	KNOWN <input checked="" type="checkbox"/> EST. <input type="checkbox"/>	MONTH		DAY	YEAR
11-26	19 83				
2b. HOUR		M			
4:05 P.M.					
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	
Female	White	June 19, 1902		81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
New Jersey		U.S.A.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	
Montgomery County, MD.		Silver Spring		Montgomery General Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. INSIDE CITY LIMITS?	
Service Manager		Woodies		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13b. STREET ADDRESS		13c. CITY OR TOWN		13d. STATE	
3437 S. Leisure World Blvd.		Silver Spring		Maryland	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	
Charles		Kathryn		No	
16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
579-38-3765		Son		PART I DEATH WAS CAUSED BY:	
David F. McConnell		Washington, D.C. 20015		IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease	
				DUE TO, OR AS A CONSEQUENCE OF	
				(b)	
				DUE TO, OR AS A CONSEQUENCE OF	
				(c)	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED	
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		P.M. 19		ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2	
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>		(AT HOME, STREET, FACTORY, FARM, ETC.)		CITY OR TOWN	
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				COUNTY	
22a. I certify that I took charge of the remains described above, held an		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/>		and in my opinion	
death resulted from		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Dennis F. Smyth, M.D.		Assistant MEDICAL EXAMINER		11-27-83	
EXAMINER'S NAME		ADDRESS			
(TYPE OR PRINT)		111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		Nov. 29, 1983		Gate of Heaven Cemetery Silver Spring Mont. Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Francis J. Collins		DEC 2 1983		John J. Collins	
NAME		ADDRESS			
500 University Blvd., W. Silver Spring, Md.					





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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				30699	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Margaret Dodge McCord</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>22</b> YEAR <b>83</b>		2b. HOUR <b>12:38 AM</b>
3. SEX <b>Female</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH <b>July</b> DAY <b>20</b> YEAR <b>1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash. D.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Chevy Chase</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE FULL STREET ADDRESS) <b>3700 Blackthorn Court</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 20815		13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Chevy Chase</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>3700 Blackthorn Court</b>
14. FATHER'S NAME FIRST <b>Horace</b> MIDDLE <b>Dodge</b> LAST <b>Dodge</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>Lovejoy</b> LAST <b>Lovejoy</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-44-4817</b>		17. INFORMANT ADDRESS <b>D.C.</b> <b>Thomas J. Egan. 1775 Penn Ave., N.W. Wash.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> <b>4920</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Obstructive Pulmonary Disease</b> <b>with Pulmonary Emphysema</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10-12 hrs.</b> <b>18-20 years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <b>11/21</b> 19 <b>83</b> , to <b>11/22</b> 19 <b>83</b> , that (I) <del>was</del> lost saw the deceased alive on <b>11/21</b> 19 <b>83</b> , and that in (my) <del>best</del> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>William O. Bailey Jr. M.D.</b>				22c. DATE SIGNED <b>11/22/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William O. Bailey Jr.</b>				22e. ADDRESS <b>2737 Devonshire Place NW, Wash. DC 20008</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>11/23/83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland Maryland.</b>
24. FUNERAL DIRECTOR <b>Joseph Gayler's Sons Inc</b> <b>5130 Wisc. Ave., N.W. Wash., D.C.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1983</b>	
				25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>	

BP

Classification: 25X/5/11  
 Project: 25X/5/11  
 Author: 25X/5/11

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 30700	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Francis A. McDonald					2a. DATE OF DEATH MONTH DAY YEAR 11/7/83			2b. HOUR 12 <sup>00</sup> P.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10/14/16		6. AGE (IN YEARS-LAST BIRTHDAY) YRS MONTHS DAYS 67		IF UNDER 1 YEAR IF UNDER 24 HRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plan. & Estimating Plumber		12b. KIND OF BUSINESS OR INDUSTRY N.I.H.			
13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Middletown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4307 Zircon Road 21769			
14. FATHER'S NAME FIRST MIDDLE LAST Samuel A. McDonald					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Chester						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWII		17. INFORMANT Clarice I. McDonald		ADDRESS Wife Same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> 4100										1 hour.	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myocardial infarction</u>										8 days.	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Anterior ischemic Heart Disease</u>										8 years.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the undersigned) attended the deceased from <u>March</u> , 19 <u>76</u> , to <u>November 7</u> , 19 <u>83</u> , that (I) (saw) saw the deceased alive on <u>November 7</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.											
22b. SIGNATURE Aaron H. Traum MD					DEGREE MD			22c. DATE SIGNED November 7, 1983			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Aaron H. Traum MD					22e. ADDRESS 8915 Georgia Ave Silver Spring Md 20910						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 10, 1983		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Frederick Frederick Md.					
24. FUNERAL DIRECTOR NAME Francis J. Collins 500 University Blvd., W. Silver Spring, Mr.					25a. DATE REC'D. BY REGISTRAR NOV 14 1983		25b. REGISTRAR'S SIGNATURE John J. Conner				

BP



*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "MAY 1941" and "RECEIVED" are faintly visible.]*

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30701

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH			2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MONICA S. McFARLAND			11 02 83			9 <sup>30</sup> PM		
3. SEX Female	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR AUG. 29 1917	6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MINNESOTA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY			13c. CITY OR TOWN SILVER SPRING		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 2101 COLERIDGE DRIVE 20910					
14. FATHER'S NAME FIRST MIDDLE LAST NICHOLAS WEBER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA vonDONNERSBACH					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. WWII 477-01-9408			17. INFORMANT SON TAN R. McFARLAND		
			ADDRESS 7419 PINEY BRANCH RD TAKOMA PARK, MD. 20912					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> 1749 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coroniosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Inflammatory Carcinoma of Breast</u> 2 days 4 months 2 yrs								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>15 Nov 1983</u> to <u>2 Nov 1983</u> , that (I) (we) lost saw the deceased alive on <u>2 Nov 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Eugene P. Libre MD			DEGREE MD			22c. DATE SIGNED 4 Nov 83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eugene P. Libre M.D.			22e. ADDRESS 10500 Conestoga Ave Kensington Md. 20851					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE NOV. 7, 1983			23c. NAME OF CEMETERY OR CREMATORY OLD ST. JOHN'S		
23d. LOCATION CITY OR TOWN COUNTY STATE FOREST GLEN MONT. MD.			24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIVERSITY BLVD., W. SILVER SPRING, MD.			25a. DATE REC'D. BY REGISTRAR NOV 14 1983		
			25b. REGISTRAR'S SIGNATURE John J. Connelley					

BP

UNITED STATES OF AMERICA  
DEPARTMENT OF THE ARMY  
OFFICE OF THE CHIEF OF STAFF



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30702

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>KATHERINE L. MCKAY</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>28</b> YEAR <b>83</b>		2b. HOUR <b>10:52 AM</b>
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH <b>August</b> DAY <b>12</b> YEAR <b>1918</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS. IF UNDER 1 YEAR: MONTHS <b></b> DAYS <b></b> IF UNDER 24 HRS: HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Switchboard Oper.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Miller Ent.</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Silver Spring</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Edward</b> MIDDLE <b>P.</b> LAST <b>McGinn</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Ellen</b> MIDDLE <b></b> LAST <b>Boyle</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>578-16-1666</b>		17. INFORMANT <b>Sister</b> ADDRESS <b>12839 Littleton St. Wheaton, Md. 20906</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute heart failure</b> 4254 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>cardiomyopathy</b> (c) <b>6-Pulse</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <b>11/28</b> , 19 <b>83</b> , to <b>11/28</b> , 19 <b>83</b> , that (1) (we) last saw the deceased alive on <b>11/28</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.					
22b. SIGNATURE <b>Milton Koch</b>		DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/29/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MILTON KOCH</b>		22e. ADDRESS <b>2101 Medical Park Dr. Silver Spring, Md. 20902</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec. 2, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Maryland Nat. Mem. Park</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Laurel Pr. Geo. Md.</b>		24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b> ADDRESS <b>500 University Blvd., W. Silver Spring, Md.</b>			
25a. DATE REC'D. BY REGISTRAR <b>DEC 6 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM VM-18. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										30703 REG. NO.			
1- FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) <b>James McKenzie</b>										<b>11/6/83</b>		<b>4:30 P.M.</b>	
3 SEX <b>Male</b>		4 RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 15 19 64</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD <b>11/6/83</b>		2d. HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b>	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>108 Croydon Court</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Maintenance</b>				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>				13b. COUNTY <b>Silver Spring</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS <b>108 Croydon Court 20901</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Lloyd Ripley McKenzie</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rebecca Brown</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>						16b. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS <b>Mrs. Ruth McKenzie Washington, D.C. 20010</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>Arteriosclerotic cardiovascular disease</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (a) _____ (b) _____ (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>11/7/83</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>Dennis F. Smyth, M.D.</b>				ADDRESS <b>111 Penn St., Balto., Md. 21201</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>				23b. DATE <b>11/16/83</b>				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>				ADDRESS <b>Balto., Md.</b>				25. DATE RECEIVED BY REGISTRAR <b>NOV 21 1983</b>				25b. REGISTRAR'S SIGNATURE <i>John J. Cappel</i>	

MEDICAL CERTIFICATION

Washington, D.C. 20540

Mr. [Name] [Address] [City] [State] [Zip]

Dear Mr. [Name]:

I am writing to you regarding [Topic].

[Detailed body text paragraph]

[Detailed body text paragraph]

[Detailed body text paragraph]

Sincerely,  
[Signature]

[Name]  
[Title]  
[Organization]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30704

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME **LUCY**  
(TYPE OR PRINT)

MIDDLE

A. **Mc LAREN**

2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR  
**Nov 9 1983 4:45 AM**

3. SEX

**Female**

4. RACE

**White**

5. DATE OF BIRTH

**3 - 22 - 1895**

6. AGE (IN YEARS LAST BIRTHDAY)

**88** YRS.

IF UNDER 1 YEAR IF UNDER 24 HRS

MONTHS DAYS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

**GRANITVILLE, MO.**

7b. CITIZEN OF WHAT COUNTRY?

**USA**8. MARRIED ☐ NEVER MARRIEDWIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

**MONTGOMERY** MD.

10. CITY OR TOWN OF DEATH

**SILVER SPRING**

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

**CHEVY CHASE NURSING HOME**

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

**ATTORNEY**

12b. KIND OF BUSINESS OR INDUSTRY

**U.S. GOVT.**

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE **D.C.**

13b. COUNTY

13c. CITY OR TOWN **WASHINGTON**13d. INSIDE CITY LIMITS? YES ☐ NO ☐13e. STREET ADDRESS **3900 CONN. AVE. NW. 99999**

14. FATHER'S NAME

FIRST **JAMES**MIDDLE **E.**LAST **Mc LAREN**

15. MOTHER'S MAIDEN NAME

FIRST **SONORA**B. MIDDLE **BEAVE**

ADDRESS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

**NO**

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

**579-52-9635**

17. INFORMANT

**MRS. EILEEN M. HARRIS**ADDRESS **430 WILLIAMS ST. PACIFIC, MO.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:

**1534**IMMEDIATE CAUSE (a) **Metastatic Disease**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **Carcinoma of Cecum**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

**3 months****3 months**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

**9/7/83**

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

**See above**

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. **19**

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ AT WORK NOT WHILE ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from **June**, 19 **83**, to **11/9**, 19 **83**, that (I) (we) last saw the deceased alive on **11/7**, 19 **83**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

**William O. Bailey, Jr. MD**

DEGREE

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

**11/9/83**

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

**William O. Bailey, Jr.**

22e. ADDRESS

**2737 Devonshire Pl., NW, Wash DC 20008**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

**BURIAL**

23b. DATE

**11/11/83**

23c. NAME OF CEMETERY OR CREMATORY

**KNOBLOCK CEME.**

23d. LOCATION CITY OR TOWN

**KNOBLOCK**

COUNTY

STATE

**MO.**

24. FUNERAL DIRECTOR

**JOS. GAWLERS' SONS****5130 WISCONSIN AVE. NW WASH., D.C.**

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

**NOV 17 1983****John J. Connel**

TABLEAU N° 100  
NOM DE LA SOCIÉTÉ : ...  
N° DE LA SOCIÉTÉ : ...



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		3 0 7 0 5				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nettie I. Mc Reynolds					2a. DATE OF DEATH MONTH DAY YEAR November 17, 1983			2b. HOUR 3:00a.m.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 25, 1887		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carriage Hill Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Agent		12b. KIND OF BUSINESS OR INDUSTRY Real Estate	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3600 Etelmyer Terr. (20902)	
14. FATHER'S NAME FIRST MIDDLE LAST William Henry Isom				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie - Whitten					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT 578-38-7382		ADDRESS William Mc Reynolds 4 Waterway Ct. Rockville, Maryland			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis 4409 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Many Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <del>did not</del> attended the deceased from <u>Nov. 16</u> , 19 <u>83</u> , to <u>Nov. 17</u> , 19 <u>83</u> , that (I) <del>had</del> last saw the deceased alive on <u>Nov. 16</u> , 19 <u>83</u> , and that in (my) <del>(my)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>did not</del> (did not) view the body after death.									
22b. SIGNATURE James Wegan MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED Nov. 17, 1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. James W. Egan, Md.				22e. ADDRESS 5413 Cedar Lane Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov/21/83		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Arlington, Virginia			
24. FUNERAL DIRECTOR NAME Chambers Funeral Home				ADDRESS Silver Spring, Maryland		25a. DATE REC'D. BY REGISTRAR NOV 21 1983			
				25b. REGISTRAR'S SIGNATURE John J. Gansel					

John G. Cook

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30706

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Lottie I. Measell</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 17 83</b>		2b. HOUR <b>2320 PM</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 20 1890</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>93 YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>	
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sec. (Signal Corps)</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov. Fed. Trade Comm</b>	
13a. STATE <b>D.C.</b>		13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Clarence Samael Measell</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Fannie Mae Gernand</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No -</b>		16b. SOCIAL SECURITY NO. <b>578-46-0198</b>	
17. INFORMANT <b>Records</b>		ADDRESS <b>201 Russell Ave.</b>		18. ASBURY METH. HOME <b>Gaithersburg, Md. 20877</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4100 IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF <b>(b) CORONARY ARTERY DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF <b>(c) ARTERIOSCLEROSIS</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 DAYS</b> <b>YEARS</b> <b>11</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 19 76</b> to <b>Date</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>11/17/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <b>Thos G. Ward</b>				22c. DATE SIGNED <b>11/18/83</b>		22d. ADDRESS <b>6116 Robin Woods, Bethesda, Md 20817</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/22/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Weller United Meth.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Thurmont Fred. Md</b>	
24. FUNERAL DIRECTOR <b>Donald H. Sandison</b>				25. DATE RECD BY REGISTRAR <b>NOV 23 1983</b>		25. REGISTRAR'S SIGNATURE <b>Paul G. Smith</b>	
Gartner Sandison F.H.				316 E. Diamond Ave.		Gaithersburg, Md. 20877	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR STATE REGISTRAR		30701	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET NMI METZEROTH		2a DATE OF DEATH MONTH DAY YEAR 11 29 83 2b HOUR 7:50 AM	
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Feb. 2, 1899	
6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC	
7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD		10 CITY OR TOWN OF DEATH Takoma Park	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher	
12b KIND OF BUSINESS OR INDUSTRY DC Schools		13a INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13b STREET ADDRESS 1108 Holton Lane 20912		14 FATHER'S NAME FIRST MIDDLE LAST John E. Metzeroth	
15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Antoinette M. Neuhaus		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) N/A N/A	
16b SOCIAL SECURITY NO 579-60-0690		17 INFORMANT ADDRESS Francis Loomis-nephew-same as 13e)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST 4140 DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) SEPSIS PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	
21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from March 19, 83, to Nov. 28, 19, 83, that (I) (we) last saw the deceased alive on Nov. 27, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b SIGNATURE Mark K. Li, MD		22c DATE SIGNED 11-29-83	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Mark K. Li, MD		22e ADDRESS 1150 Varnum Street, N.E. Washington, D.C.	
23a BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b DATE Dec. 2, 1983	
23c NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24 FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home		25a DATE REC'D BY REGISTRAR DEC 1 1983	
25b REGISTRAR'S SIGNATURE John J. Gavigan		25c REGISTRAR'S SIGNATURE	

DEC 1 1983  
J. G. G. G.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30708

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>NETTIE O. MILES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 26 83</b>		2b. HOUR <b>2:12pM</b>
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9 15 1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>OLNEY</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MONTGOMERY GENERAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE AS WORK FOR MOST OF WORKING LIFE) <b>Domestic</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>MD</b>	13b. COUNTY <b>Howard</b>	13c. CITY OR TOWN <b>Glenwood</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>3332 Rt. 97 Glenwood</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Oliver Scott Miles Jr.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Isabel S Dorsey</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>219308117</b>		17. INFORMANT ADDRESS <b>Helena Gaither - Glenwood, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: <b>4140 IMMEDIATE CAUSE (a) Cardio respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>prob Arterio Sclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>unknown</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 hr</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>1) Diabetes Mellitus, Insulin Dependent 2) Hypertension</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 19 83</b> to <b>Nov 26 19 83</b> , that (I) (we) last saw the deceased alive on <b>Oct 19 83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Daniel L. Anderson</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/26/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Daniel L. Anderson</b>		22e. ADDRESS <b>Olney, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>12-1-83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Gregory Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bushy Park HOWARD MD</b>	
24. FUNERAL DIRECTOR NAME <b>Harry W Haight</b>		ADDRESS <b>Sykesville</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 29 1983</b>	25b. REGISTRAR'S SIGNATURE <b>John S. Smith</b>

MEDICAL CERTIFICATION  
Charles E. Medical Examiner - M. Hays

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30709

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EVA MILLER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 2 83</b>		2b. HOUR <b>11:15 P.M.</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 30, 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <b>85 YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Massachusetts</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>	
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Hebrew Home of Greater Washington</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesperson</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Cosmetics</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Ch Chase</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Abram Ruben</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lena Hindofsky</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>019-26-5819</b>	
17. INFORMANT ADDRESS <b>Alex., Va.</b>		17. INFORMANT <b>Alan Miller; 5801 Quantrelle Ave.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b> <b>5990</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PROBABLE SEPSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>PRIMARY TRACT INFECTION</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>—</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>SEVERE DEMENTIA</b>							
19a. DATE OF OPERATION <b>11/2</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>19</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>19</b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11/6 7:30 P.M.</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>11/6 7:30</b>		21d. LOCATION STREET CITY OR TOWN COUNTY STATE <b>11/2 11/2 11/2</b>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>11/6</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>11/2 11/2 11/2</b>		21g. CERTIFY THAT (1) THIS HOSPITAL ATTENDED THE DECEASED FROM <b>11/2</b> TO <b>11/2</b> 19 <b>83</b> THAT (1) (I) SAW THE DECEASED ALIVE ON ABOVE DATE (I) DID NOT VIEW THE BODY AFTER DEATH.		21h. SIGNATURE <b>Robert L. Rosenberg, MD</b>	
21i. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT L. ROSENBERG, MD</b>		21j. ADDRESS <b>1131 UNIVERSITY BLVD. W., SILVER SPRING, MD 20902</b>		21k. DATE SIGNED <b>11/3/83</b>		21l. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-7-1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>B'nai B'Rith Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Worcester, Mass.</b>	
24. FUNERAL DIRECTOR <b>Danzansky-Goldberg Chapels; 1170 Rockville Pike</b>		24. DATE RECD. BY REGISTRAR <b>NOV 8 1983</b>		24. REGISTRAR'S SIGNATURE <b>John J. Gough</b>			

1944

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH30710  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Harold E. Miller</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Oct. 24, 1983</b>		2b. HOUR <b>5:05 PM</b>			
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 5, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>83</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.		
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Chief-Bureau of Rates &amp; Gas</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>				13b. CITY OR TOWN <b>Montgomery</b>		13c. STREET ADDRESS <b>Takoma Pk. 7051 Carroll Ave. 20912</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Max Miller</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lena Schneider</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>WWI WWII 049 10 3719</b>	
17. INFORMANT <b>Suzy Van Massenhove</b>				ADDRESS <b>Falls Church, Va.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-respiratory arrest</b> <b>250D</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetic and arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>urinary infection and subdural hygroma</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this physician) attended the deceased from <b>10-18</b> , 19 <b>83</b> , to <b>10-24</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>10-24</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <b>xx</b>								
22b. SIGNATURE <b>Hamid Montakhab</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Hamid Montakhab, M.D.</b>				22e. ADDRESS <b>6111 Executive Blvd., Rockville, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Oct. 26, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Quantico Nat'l.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Quantico, Virginia</b>		
24. FUNERAL DIRECTOR NAME <b>Lives-Pearson Funeral Homes</b>				ADDRESS <b>Falls Church, Va. 22046</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 18 1983</b>		
				25b. REGISTRAR'S SIGNATURE <b>John J. Carney</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner and the medical examiner's office.



NOV 18 1953  
R. G. G. G.



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NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 301-358-1111.

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BP

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 30711		
1. FOR STATE REGISTRAR										2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST										11 19 83		8:10 AM
Ray O. MILLER												
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALE		WHITE		MONTH DAY YEAR		80 YRS.		MONTHS DAYS		HOURS MIN.		
12 2 02												
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
MARYLAND		U.S.A.				MONTGOMERY MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Beth. Maryland		Suburban Hospital										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS				
—		—		WASH. D.C.				4317 RIVER ROAD, N.W. 99999				
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
STALEY MILLER				EMMA SAUCER								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
No				577-05-1806		WIFE - MARGIE P. MILLER - SAME AS #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
4960 IMMEDIATE CAUSE (a) acute respiratory failure												
DUE TO OR AS A CONSEQUENCE OF (b) Pneumonia												
DUE TO OR AS A CONSEQUENCE OF (c) Chronic obstructive pulm												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
Esophageal ulcer, atrial arrhythmias												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
		P.M. 19										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 11/6 19 83, to 11/19 19 83, that (I) (X) last saw the deceased alive on 11/19 83, and that in my (X) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED		
22b. SIGNATURE DEGREE										22c. DATE SIGNED		
Robert J. Subbaford										11/19/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE						
BURIAL		11-22-83		FT. LINCOLN Cem		WASHINGTON D.C.						
24. FUNERAL DIRECTOR										25. DATE REC'D. BY REGISTRAR		
James R. DeVore										NOV 22 1983		
DE VORE FUNERAL HOME WASH. D.C.										John J. Gault		

CHIEFLIN



Dr. J. H. ...  
100 S. S. ...  
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State of ...  
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. GIVE PAGE 6 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 30712	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <u>Virginia Rose Mills</u>						2a. DATE KNOWN OF DEATH <u>NOV 9 1983</u>					
3. SEX <u>F</u>		4. RACE <u>W</u>		5. DATE OF BIRTH <u>FEB 13 1924</u>		6. AGE (IN YEARS) <u>62</u> YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>WASHINGTON DC</u>				7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery MD.</u>	
10. CITY OR TOWN OF DEATH <u>Lt K PK.</u>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Wash. Advent. Hosp</u>				12a. USUAL OCCUPATION (TYPE WORKER FOR MOST OF WORKING LIFE) <u>FED GOVT.</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>GOV. RT. OFFICER</u>	
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <u>MD</u>		13b. COUNTY <u>PR GEO</u>		13c. CITY OR TOWN <u>TAKOMA PARK</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>1001 ELM AVENUE 20912</u>			
14. FATHER'S NAME FIRST <u>EDMUND</u> MIDDLE <u>KEITH</u>				15. MOTHER'S MAIDEN NAME FIRST <u>MELROSE</u> MIDDLE <u>STEADMAN</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>NO</u>				16b. SOCIAL SECURITY NO. <u>578-18-5492</u>				17. INFORMANT ADDRESS <u>RAYMOND E. MILLS - 1001 ELM AVE TR</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <u>4291</u> IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>None</u>											
19a. DATE OF OPERATION <u>None</u>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>John S. Rogers</u>				TITLE (SPECIFY) <u>M.D. Dep.</u>				MEDICAL EXAMINER DATE SIGNED <u>NOV 9 1983</u>			
EXAMINER'S NAME (TYPE OR PRINT) <u>JOHN S. ROGERS</u>				ADDRESS <u>1919 SEMINARY RD. SS. MD</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				23b. DATE <u>Nov. 12 1983</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>				23d. LOCATION CITY OR TOWN COUNTY STATE <u>Brentwood P.D. Md</u>	
24. FUNERAL DIRECTOR NAME <u>Tokom Funeral Home</u> ADDRESS <u>254 Central Blvd D</u>				25. DATE REC'D. BY REGISTRAR <u>NOV 14 1983</u>				25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 30713	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JOHN CLARENCE MOBBERLEY</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>October 14, 1983</b>		2b. HOUR <b>4 M</b>	
3 SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan 8 1905</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS		IF UNDER 1 YEAR MONTHS DAYS <b>MONTH</b>		IF UNDER 24 HRS HOURS MIN. <b>MD.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10 CITY OR TOWN OF DEATH <b>Gaithersburg</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8910 Centerway Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Executive</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Office Supply</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Gaithersburg</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>8910 Centerway Road</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>John T. Mobberly</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eva G. Williams</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>577-03-9682</b>		17 INFORMANT <b>Mrs. Marjorie C. Mobberly</b>		ADDRESS <b>8910 Centerway Rd. Gaithersburg, Md.</b>					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4148</b> IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>6-7 1983</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>19</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Rockville MD 20850</b>							
22a. I certify that (I) (this hospital) attended the deceased from <b>6-7 1983</b> to <b>8-30 1983</b> , that (I) (we) lost saw the deceased alive on <b>8-30 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>John E. Kelly</b>		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10.14.83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN E. KELLY</b>				22e. ADDRESS <b>9715 MEDICAL CENTER DR ROCKVILLE MD 20850</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-18-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Memorial National Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Falls Church, Va.</b>					
24 FUNERAL DIRECTOR NAME ADDRESS <b>ARLINGTON FUNERAL HOME -- ARLINGTON, VIRGINIA</b>						25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE <b>OCT 25 1983</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified and a post-mortem examination will be required.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30714

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ETHEL R. MOORE</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>November 18, 1983</b>		2b. HOUR <b>11:38pm</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 20, 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS <b>75</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital Cafeteria worker</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ind. of Education</b>		12b. INDUSTRY <b>Montg. County</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph N. Holland</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Frances Roberta Baggott</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>N/A</b>		16b. SOCIAL SECURITY NO. <b>578-42-3847</b>	
17. INFORMANT ADDRESS <b>Robert G. Moore-son Woodbine, Md. 21797</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4254 Congestive Cardiomyopathy</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arterioarteriole Heart Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes Mellitus</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>June 3, 1981</b> to <b>Nov 18, 1983</b> , that (I) (we) last saw the deceased alive on <b>Nov 18, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Michael A. Bolognese</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/19/83</b>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Michael A. Bolognese, MD</b>		22c. ADDRESS <b>15 E. Deer Park Dr., Gaithersburg, Md.</b>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-21-83</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rockville Union</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rockville Montgomery Md.</b>		24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi Funeral Home</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 22 1983</b>	
25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>		25c. ADDRESS <b>11800 N.H. Ave., S.S. Md.</b>		25d. DATE REC'D. BY REGISTRAR <b>NOV 22 1983</b>		25e. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	

BP



NOV 1961



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR OFFICE. IF YOU ARE THE FUNERAL DIRECTOR, PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

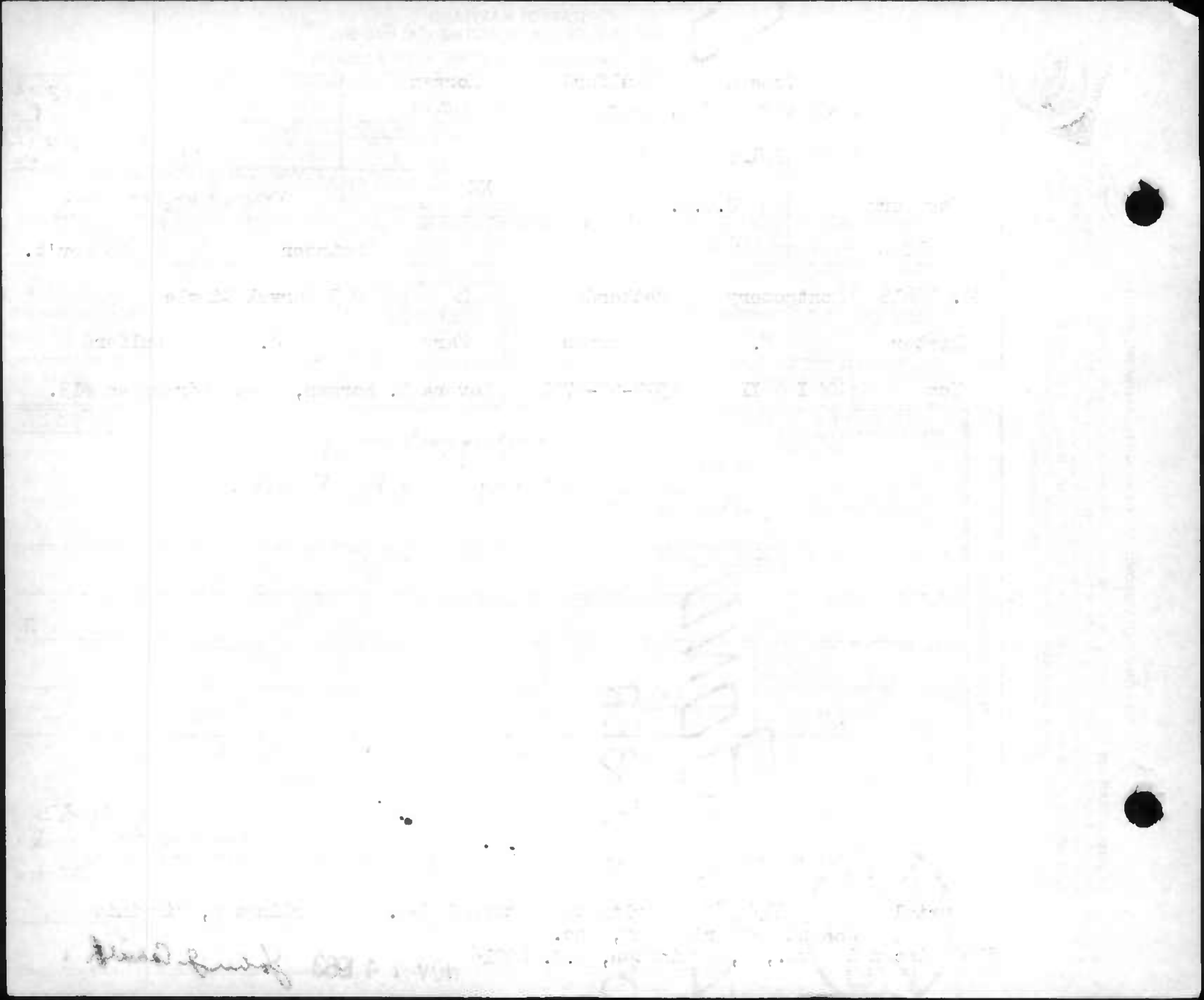
DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Joseph Mulford Morgan</b>			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR <b>11 4 83</b>			2b. HOUR P.M. <b>8 12</b>		
3. SEX <b>MALE</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>JULY 1, 1899</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>84</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>11 4 83</b>	2d. HOUR P.M. <b>8 12</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.		
10. CITY OR TOWN OF DEATH <b>Suburban Hospital - Bethesda Md</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Engineer</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>US Gov't.</b>								
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION):								
13a. STATE <b>Md.</b>	13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Bethesda</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b># 3 Carvel Circle</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Chester M. Morgan</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary J. Mulford</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW I &amp; II</b>		17. INFORMANT ADDRESS <b>Mavera E. Morgan, Same address as #13.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>asphyxiation</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <b>aspiration of food</b> (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>John Tauber</b>		M.D.		TITLE (SPECIFY)		DATE SIGNED <b>11-4-83</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>John Tauber</b>		ADDRESS <b>Bethesda Md. 8218 Wisconsin Ave</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/8/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington, Virginia</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave., NW, Washington, D.C. 20016</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1983</b>		25b. REGISTRAR'S SIGNATURE <b>James G. Gault</b>		



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30716

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>SAMUEL JOHNSON MORRIS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 1 1983</b>		2b. HOUR <b>11:31<sup>a</sup></b>
3. SEX <b>MALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>JANUARY 1 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>DELAWARE</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.		10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. NAVY</b>		13a. STREET ADDRESS <b>9 CARVER STREET</b> <b>21401</b>	
13b. STATE <b>MARYLAND</b>		13c. COUNTY <b>ANNE ARUNDEL</b>		13d. CITY OR TOWN <b>ANNAPOLIS</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN MORRIS</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LEE ANN HANDY</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>1919-1949</b>		17. INFORMANT ADDRESS <b>LOUISE FRANKLIN, 714 MYRTLE AVE., APT 4</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4280 IMMEDIATE CAUSE (a) PULMONARY EMBOLI</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 14, 1983</b> to <b>NOVEMBER 1, 1983</b> , that (I) (we) lost saw the deceased alive on <b>NOVEMBER 1, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JEANNE P. ASHER, LT, MC, USNR</b>		22c. DATE SIGNED <b>3 Nov 83</b>		22d. ADDRESS <b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/6/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pine Lawn</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>ANNAPOLIS MD.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Charles Hicks 1922 Forest Dr</b>			
25a. DATE RECEIVED BY REGISTRAR <b>NOV 4 1983</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

NO. 2



2000 COLL.

CHIEF

1. The first part of the report is a general statement of the work done during the year. It is a summary of the work done by the various departments and is intended to give a general idea of the progress made. It is not a detailed report of the work done, but a general statement of the work done.

2. The second part of the report is a detailed statement of the work done by the various departments. It is a summary of the work done by the various departments and is intended to give a general idea of the progress made. It is not a detailed report of the work done, but a general statement of the work done.

3. The third part of the report is a detailed statement of the work done by the various departments. It is a summary of the work done by the various departments and is intended to give a general idea of the progress made. It is not a detailed report of the work done, but a general statement of the work done.

4. The fourth part of the report is a detailed statement of the work done by the various departments. It is a summary of the work done by the various departments and is intended to give a general idea of the progress made. It is not a detailed report of the work done, but a general statement of the work done.

5. The fifth part of the report is a detailed statement of the work done by the various departments. It is a summary of the work done by the various departments and is intended to give a general idea of the progress made. It is not a detailed report of the work done, but a general statement of the work done.

6. The sixth part of the report is a detailed statement of the work done by the various departments. It is a summary of the work done by the various departments and is intended to give a general idea of the progress made. It is not a detailed report of the work done, but a general statement of the work done.

7. The seventh part of the report is a detailed statement of the work done by the various departments. It is a summary of the work done by the various departments and is intended to give a general idea of the progress made. It is not a detailed report of the work done, but a general statement of the work done.

8. The eighth part of the report is a detailed statement of the work done by the various departments. It is a summary of the work done by the various departments and is intended to give a general idea of the progress made. It is not a detailed report of the work done, but a general statement of the work done.

9. The ninth part of the report is a detailed statement of the work done by the various departments. It is a summary of the work done by the various departments and is intended to give a general idea of the progress made. It is not a detailed report of the work done, but a general statement of the work done.

10. The tenth part of the report is a detailed statement of the work done by the various departments. It is a summary of the work done by the various departments and is intended to give a general idea of the progress made. It is not a detailed report of the work done, but a general statement of the work done.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 30717	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>ELEANOR M. MORRISON</u>				2a. DATE OF DEATH MONTH DAY YEAR <u>11-7-83</u>	
3. SEX <u>Female</u>		4. RACE <u>Caucasian</u>		2b. HOUR <u>3:05 AM</u>	
5. DATE OF BIRTH MONTH DAY YEAR <u>7-12-1909</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>74</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Pennsylvania</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.	
10. CITY OR TOWN OF DEATH <u>Olney</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>BROOKE GROVE NURSING H</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>1st. Col. W.A.C.</u>	
12b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Army</u>		13a. STREET ADDRESS <u>14702 Bigby Court</u>		20906	
13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Silver Spring</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Frank Morrison</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Mabel Campbell</u>		17. INFORMANT ADDRESS <u>Friend 14702 Bigby Court</u>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Yes</u>		16b. SOCIAL SECURITY NO. <u>307-20-2098</u>		17. INFORMANT ADDRESS <u>Alta M. McDermott Silver Spring, Md. 20906</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <u>1749</u> IMMEDIATE CAUSE (a) <u>Brain Cancer, with Bone Metastases</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>83</u> , to <u>Nov 7</u> , 19 <u>83</u> , that (I) (we) lost <u>saw</u> the deceased alive on <u>Nov 7</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Eugene P. Flannery</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>11/7/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>EUGENE P. FLANNERY, MD</u>		22e. ADDRESS <u>18111 PRINCE PHILIP DR. OLNEY, MD. 20832</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Nov. 10, 1983</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	
23d. LOCATION CITY OR TOWN COUNTY STATE <u>Arlington Virginia</u>		24. FUNERAL DIRECTOR NAME <u>Francis J. Collins</u>		25a. DATE REC'D. BY REGISTRAR <u>NOV 14 1983</u>	
500 University Blvd., W. Silver Spring, Md.		25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>			

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30718

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WILLIAM EDWARD MORRISON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 26 1983</b>		2b. HOUR P M <b>10:35 P</b>					
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MARCH 15 1923</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>60</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN. <b>10:35 P</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>KENTUCKY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.				
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. ARMY</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>KENSINGTON</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>10102 CEDAR LANE</b> 20895	
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII</b>		17. INFORMANT Wife - <b>GRACE S. MORRISON, 10102 CEDAR LANE,</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GASTROINTESTINAL BLEEDING</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 22, 1983</b> to <b>NOVEMBER 26, 1983</b> , that (I) (we) last saw the deceased alive on <b>NOVEMBER 26, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>H. R. Alexander M.D.</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>28 Nov 1983</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>H. RICHARD ALEXANDER, LT, MC, USNR</b>			22e. ADDRESS <b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Dec 1 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington Va.</b>		
24. FUNERAL DIRECTOR NAME <b>Demaine Funeral Homes, Inc., Alex., Va. 22314</b>			ADDRESS <b>Alex., Va. 22314</b>			25a. DATE REC'D. BY REGISTRAR <b>DEC 01 1983</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i>		

MEDICAL CERTIFICATION

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

STATION 2015A-1100





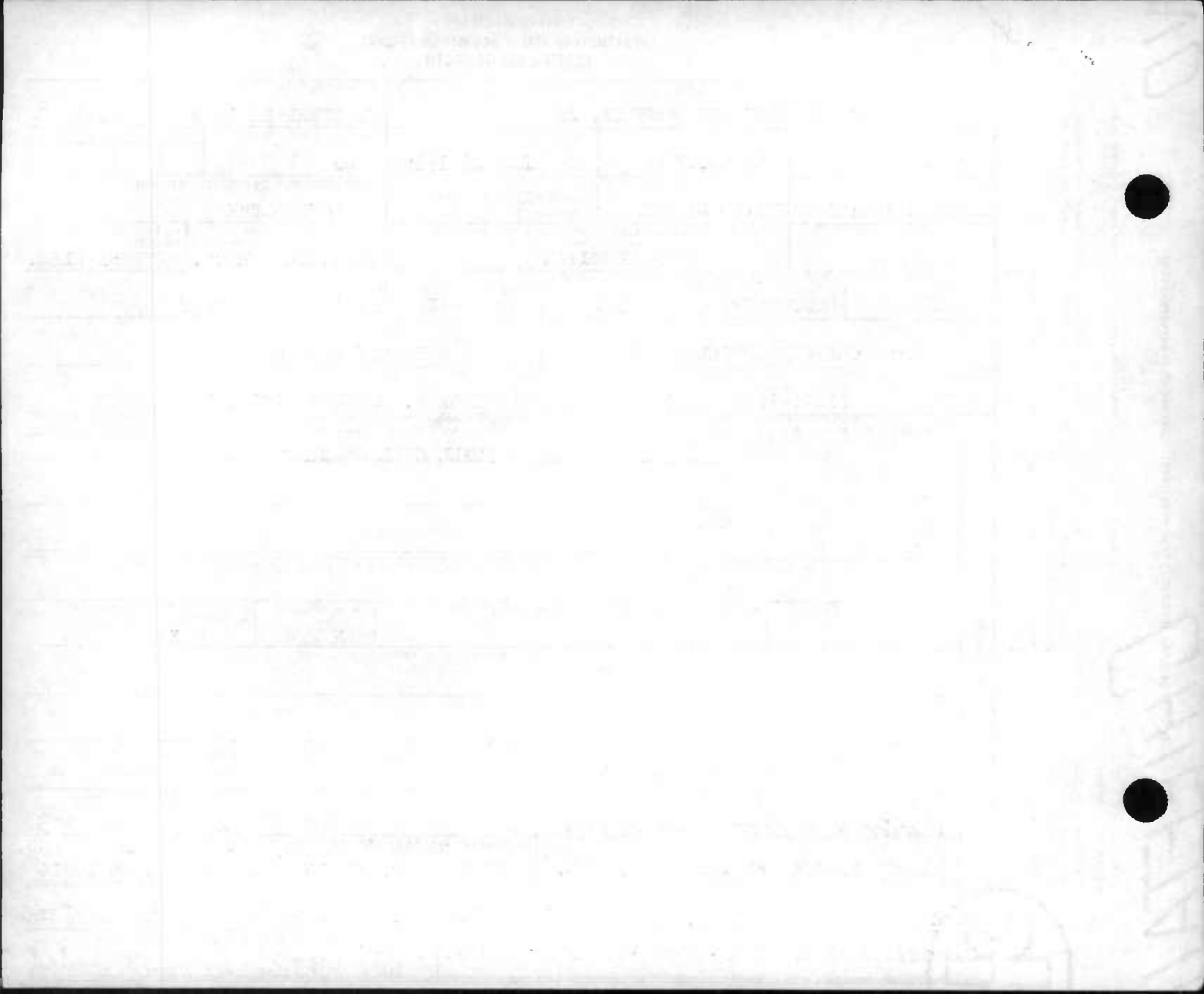
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30719

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
JAMES CLEBURNE MOSELEY, JR						NOVEMBER 22 1983			7:30 P <sub>M</sub>			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		CAUCASIAN		MONTH DAY YEAR DECEMBER 31 1919		63 YRS.			MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
SOUTH CAROLINA		UNITED STATES				MONTGOMERY MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
BETHESDA		NAVAL HOSPITAL				ELECTRICAL ENGR.			DEFENSE ELEC.			
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
MARYLAND			MONTGOMERY		WHEATON				3101 VERONA COURT 20906			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
JAMES CLEBURNE MOSELEY				MARGARET KUNKEL								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS						
YES		1941-1946		577-22-2018		ELFRIEDE M. MOSELEY, 3101 VERONA COURT,						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>WIDELY METASTATIC SMALL CELL CARCINOMA</u> <u>1991</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>NOVEMBER 14</u> , 19 <u>83</u> , to <u>NOVEMBER 22</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>NOVEMBER 22</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Victor Aletich</u> LCDR MC USNR MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>23 Nov 83</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Victor</u> VICTOR ALETICH, LCDR, MC, USNR						22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			11/26/83		Parklawn Cemetery			Rockville Mont. Maryland				
24. FUNERAL DIRECTOR Hines/Rinaldi 11800 New Hampshire Ave.						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
						NOV 28 1983		<u>Joan L. Connel</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 77 before with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30720

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOURS MIN.	
MILDRED C. MOTTERN		NOV. 24, 1983		2 A M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. BALTIMORE CITY OR COUNTY OF DEATH	
Female	White	MONTH DAY YEAR	75 YRS.	Montgomery MD.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9. CITIZEN OF WHAT COUNTRY?	10. MARried <input type="checkbox"/> NEVER MARried <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	11. BALTIMORE CITY OR COUNTY OF DEATH		
Penn.	USA	Montgomery			
12. CITY OR TOWN OF DEATH	13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	15. KIND OF BUSINESS OR INDUSTRY		
Silver Spring	15505 Prince Frederick Way	Eng. Asst.	Telephone		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	17. STATE	18. COUNTY	19. CITY OR TOWN	20. INSIDE CITY LIMITS?	21. STREET ADDRESS
16a. Md. 20906	17a. Mont.	18a. Silver Spring	19a. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	21a. 15505 Prince Frederick Way	
22. FATHER'S NAME	23. MOTHER'S MAIDEN NAME	24. INFORMANT ADDRESS			
22a. FIRST MIDDLE LAST	23a. FIRST MIDDLE LAST	24a. ADDRESS			
Woodward - Wyant	Bessie - Dorvit	Ann C. Lake Derwood, Md. 20855			
25. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	26. SOCIAL SECURITY NO.	27. INFORMANT ADDRESS			
no	168-22-8562	Ann C. Lake Derwood, Md. 20855			
28. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suspected Cardiac Arrhythmia</u> <u>4279</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
29. DATE OF OPERATION	30. CONDITION FOR WHICH OPERATION WAS PERFORMED	31. AUTOPSY?	32. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
29a. DATE OF OPERATION	30a. CONDITION FOR WHICH OPERATION WAS PERFORMED	31a. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	32a. YES <input type="checkbox"/> NO <input type="checkbox"/>		
33. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	34. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	35. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
33a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	34a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	35a. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
36. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>	37. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	38. LOCATION STREET CITY OR TOWN COUNTY STATE	39. LOCATION STREET CITY OR TOWN COUNTY STATE		
36a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>	37a. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	38a. LOCATION STREET CITY OR TOWN COUNTY STATE	39a. LOCATION STREET CITY OR TOWN COUNTY STATE		
40. I certify that (I) (this hospital) attended the deceased from <u>3/79</u> 19 <u>483</u> , to <u>4/83</u> 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>4/83</u> 19 <u>83</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
41. SIGNATURE	42. DEGREE	43. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	44. DATE SIGNED		
41a. SIGNATURE	42a. DEGREE	43a. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	44a. DATE SIGNED		
45. PHYSICIAN'S NAME (TYPE OR PRINT)	46. ADDRESS		47. DATE REC'D BY REGISTRAR		
45a. PHYSICIAN'S NAME (TYPE OR PRINT)	46a. ADDRESS		47a. DATE REC'D BY REGISTRAR		
JOEL GOOZH	4701 RANDOLPH RD ROCKVILLE MD 20852		NOV 30 1983		
48. BURIAL, CREMATION, REMOVAL	49. DATE	50. NAME OF CEMETERY OR CREMATORY	51. LOCATION CITY OR TOWN COUNTY STATE		
Burial	Nov. 28, 1983	Arlington National	Arlington Va.		
52. FUNERAL DIRECTOR	53. DATE REC'D BY REGISTRAR		54. REGISTRAR'S SIGNATURE		
52a. FUNERAL DIRECTOR	53a. DATE REC'D BY REGISTRAR		54a. REGISTRAR'S SIGNATURE		
FRANCIS H. BARBER LAYTONSVILLE, MD. 20879	NOV 30 1983		John J. Carver		

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30721

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Baker		Moy		11 - 20 - 1983		10:32 A			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
male		Chinese		March 9, 1922		61 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Wash. D.C.		USA				Montgomery		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. NAME OF BUSINESS OR INDUSTRY			
silver Spring		Holy Cross Hospital		red. Gov't		Examiner			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.		PG		Beltsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		11945 Beltsville Road	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Moy		Chee		Nie		Eng		Jui Hi	
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		19. IF YES, GIVE WAR OR DATES		20. 579 22 1112		21. Ruth Moy (Wife)		Same as 13e	
Yes		WWII							
18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiogenic Shock</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (c) <u>Atherosclerotic Heart Disease</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>Colon Carcinoma and Anemia</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION					
AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 19</u> , 19 <u>83</u> , to <u>Nov. 20</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>Nov. 20</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
<u>Phillip W. Poth, M.D.</u>						<u>Nov. 21, 1983</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. ADDRESS		22g. ADDRESS			
Phillip W. Poth, M.D.		Suite 240, 818 18th St. N.W.		Washington D.C. 20006					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		11/25/83		George Washington		Adelphi		PG COUNTY Maryland	
24. FUNERAL DIRECTOR		24b. ADDRESS		24c. ADDRESS		24d. ADDRESS			
Hines/Rinaldi		11800 New Hampshire Ave		S.E. Md.					
						NOV 22 1983			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

COPIES OF THE  
RECORDS OF THE  
UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D. C. 20246



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 7 2 2

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <u>George</u> <u>Moy, Sr.</u>			2a. DATE OF DEATH MONTH <u>11</u> DAY <u>25</u> YEAR <u>83</u>			2b. HOUR <u>6:19</u> M		
3. SEX <u>Male</u>		4. RACE <u>Chinese</u>		5. DATE OF BIRTH MONTH <u>NOV.</u> DAY <u>5</u> YEAR <u>1905</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>78</u> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>China</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.		
10. CITY OR TOWN OF DEATH <u>Bethesda</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Suburban Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Dry Cleaning, Ldy.</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Maryland</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Rockville</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST <u>Moy</u> MIDDLE <u>Yang</u> LAST <u>Lee</u>		15. MOTHER'S MAIDEN NAME FIRST <u>Ng</u> MIDDLE <u>Lan</u> LAST <u>Hoy</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>N/A</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <u>N/A</u>		17. INFORMANT ADDRESS <u>Liv How Moy-wife- (same as 13e)</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>2898</u> <u>Brachopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aspiration Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myeloblastic MYELOID METAPLASIA</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3-4 yrs</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 15</u> , 19 <u>82</u> , to <u>Nov 25</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>Nov 25</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Eugene P. Libre MD</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>27 Nov 83</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>EUGENE P. LIBRE MD</u>		22e. ADDRESS <u>10400 Connecticut Kensington, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>11-29-1983</u>		23c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Hyattsville Pr. Georges Md.</u>		
24. FUNERAL DIRECTOR <u>Hines/Rinaldi Funeral Home</u>		11800 N.H. Ave. <u>Silver Spring, Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>NOV 28 1983</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEMORANDUM FOR THE RECORD  
SUBJECT: [Illegible]

[The body of the memorandum contains several paragraphs of text that are extremely faint and illegible due to the quality of the scan. The text appears to be organized into a standard memorandum format with a header, a body, and a closing section.]





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30723

REG. NO.

1 - FOR  
STATE  
REGISTER

1. DECEASED NAME (TYPE OR PRINT) <b>DOROTHY</b> <b>Parton</b> <b>MULLER</b> <b>Muller</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-26-83</b>			2b. HOUR <b>3<sup>45</sup> PM</b>				
1. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 15 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD. STATE <b>20815</b> COUNTY <b>Montgomery</b> CITY OR TOWN <b>Chevy Chase</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS <b>4701 Willard Ave. 20815</b>				
14. FATHER'S NAME FIRST <b>Israel</b> MIDDLE <b>Parton</b> LAST <b>Parton</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Ann</b> MIDDLE <b>O'Brien</b> LAST <b>O'Brien</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>113-07-8314</b>		17. INFORMANT ADDRESS <b>Maryland</b> <b>Alfred Muller, 4450 S. Park Ave Chevy Chase</b>						
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> <b>1749</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>metastatic carcinoma</b> (c) <b>carcinoma breast</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>1 yr</b> <b>2 yrs</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 19 83</b> to <b>date</b> 19 <b>83</b> , that (b) (we) last saw the deceased alive on <b>11/25/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.										
22b. SIGNATURE <b>Thos G. Ward</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/26/83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thos G. WARD, 6116 Robinson, Bethesda 20814</b>			22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>12/1/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Poughkeepsie Rural Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Poughkeepsie New York</b>			
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons Inc.</b> 5130 Wisc. Ave., N.W. Wash., D. C.						25a. DATE REC'D. BY REGISTRAR <b>NOV 30 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>		



New York

U.S.A.

xx

April 19 1944

cc

Miller

London

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Home

Home

1944 April 19

Montgomery Chevy Chase

Mr. X

London

London

London

London

London

1944 April 19 1944

cc

12/1/1943  
Joseph J. ...  
1130 ...  
12/1/1943  
Joseph J. ...  
1130 ...

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. OBTAIN PAGE 5 FROM THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

30724

1. DECEASED NAME (TYPE OR PRINT) <b>PAULINE J. MULLIKIN</b>										2a. DATE KNOWN OF DEATH MONTH <b>11</b> DAY <b>05</b> YEAR <b>1983</b>		2b. HOUR <b>12</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>12</b> DAY <b>06</b> YEAR <b>1924</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS.	IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.	IF UNDER 24 HRS. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.	2c. DATE PRONOUNCED DEAD MONTH <b>11</b> DAY <b>05</b> YEAR <b>1983</b>		2d. HOUR <b>6</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hosp</b>			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sales</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Hecht Co.</b>				13a. STATE <b>MD</b>					
13b. COUNTY <b>Mont</b>				13c. CITY OR TOWN <b>Silver Spring</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
13e. STREET ADDRESS <b>14213 Georgia Ave</b>				13f. ZIP CODE <b>20906</b>				14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b>F.</b> LAST <b>Curtis</b>					
15. MOTHER'S MAIDEN NAME FIRST <b>Lillian</b> MIDDLE <b>Payne</b> LAST <b>Payne</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>578-01-5048</b>					
17. INFORMANT <b>Son</b>				ADDRESS <b>13709 Wagon Way Silver Spring, MD. 20906</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>8849</b> IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Fracture Rt. Hip</b> (c) <b>Fall</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>None</b>													
19a. DATE OF OPERATION <b>Oct 22, 83</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Fracture Rt. Hip</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>6 P.M. 06/24/83</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>Fell on Curbs</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Street</b>				21f. LOCATION STREET <b>Georgia Ave.</b> CITY OR TOWN <b>Silver Spring</b> COUNTY <b>Mont</b> STATE <b>MD</b>					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE <b>John S. Rogers</b>				TITLE (SPECIFY) <b>MD. Dep.</b>				MEDICAL EXAMINER DATE SIGNED <b>Nov 07 1983</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>				ADDRESS <b>1919 Seminary Road Silver Spring, Md.</b>				23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>					
23b. DATE <b>Nov. 8, 1983</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>				23d. LOCATION CITY OR TOWN <b>Suitland</b> COUNTY <b>Pr. Geo.</b> STATE <b>Md.</b>					
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1983</b>				25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>					
500 University Blvd., W. Silver Spring, Md.													

WILLIAM

1

7071007



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30725

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Edward</b> <b>Murphy</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>11-5-83</b>		2b. HOUR <b>2:15</b> M
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Sept. 13, 1899</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Takoma Park, Md.</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Attorney</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Private</b>
13a. STATE <b>Md.</b>	13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Rockville</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>4408 Bayne Street</b> <b>20853</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Patrick Murphy</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Blansfield</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1918 - 1921</b>	17. INFORMANT <b>6110 Brook Drive</b> <b>M. Junior Bridge Falls Church, Va. 22044</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>1541</b> IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage of the brain</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Intoxication from mental carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a); stating the underlying cause lost.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>5 years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>10-11-83</b> to <b>11-3-83</b> , that (we) (we) saw the deceased alive on <b>11-2-83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Seruch T. Kimble MD</b>		DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-3-83</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Seruch T. Kimble</b>		22e. ADDRESS <b>9801 Georgia Ave, Silver Spring, Md</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>11/5/83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Md</b>	
24. FUNERAL DIRECTOR NAME <b>1331 Rockville Pike, Rockville, Md.</b> <b>Tyson Wheeler Funeral Home, Inc.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 10 1983</b>	25b. REGISTRAR'S SIGNATURE <b>John J. Lohr</b>	

14-00000 74-1000000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE KNOWN OF DEATH				2c. DATE PRONOUNCED DEAD		2d. HOUR	
HE IDE		G.		MURPHY						11 21 1983		11:45 PM			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.							
Female	White	3 10 43		40		MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH							
Germany		USA		WIDOWED		DIVORCED		Montgomery County							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Bethesda		Suburban Hospital		Housewife											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Md.		Mont.		Brookville		YES		19109 Treadway Road		20833					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
UNK		Hilda		No		528 70 9032		Thomas Murphy (Husband)		Same as 13E					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Multiple injuries with complications															
8120															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.															
DUE TO, OR AS A CONSEQUENCE OF															
(b)															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
												YES NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)							
				3:30 P.M. 10-24-1983				Driver of auto in multiple vehicle collision.							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION							
				road				Rt. 97 north of Olney Montgomery Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED							
Ann M. Dixon, M.D.				M.D. Assistant				MEDICAL EXAMINER				11-22-83			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS				111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
Burial				11/25/83				Gate of Heaven				S.S. Mont. Maryland			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Hines/Rinaldi				11800 New Hampshire Ave. S.S. Md. 3 1983				John J. Conish							

BP

ASIAN SCIENCE  
JOURNAL OF THE  
ASIAN SCIENCE SOCIETY  
VOLUME 1, NUMBER 1, 1972





Dr Rogers Notified 4:10 PM 11-16-83  
DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be procured within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 must be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30727

REG. NO.

1. STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Mathilde Weber Murray</b>		MONTH DAY YEAR <b>11-16-83</b>		HOUR MINUTE <b>3:37 P M</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH DAY MONTH YEAR <b>Dec. 2, 1919</b>	6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS <b>63</b>	IF UNDER 1 YEAR IF UNDER 24 HRS	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Germany</b>	8. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	10. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD</b>		
11. CITY OR TOWN OF DEATH <b>College Park</b>	12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>	13a. USUAL OCCUPATION (GIVE LAST WORK FOR MOST OF WORKING LIFE) <b>Ret. Clerk</b>	13b. KIND OF BUSINESS OR INDUSTRY <b>Univ. of Md.</b>		
13a. STATE <b>Maryland</b>	13b. COUNTY <b>P.G.</b>	13c. CITY OR TOWN <b>College Park</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>4609 Guilford Road 20740</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alois Weber</b>	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Berta Weichert</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		
16a. SOCIAL SECURITY NO. <b>579-22-3752</b>		17. INFORMANT ADDRESS <b>Mr. James P. Murray Chesapeake Beach, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ICF VENTRICULAR FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>PULMONARY EDEMA</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>CONDUCTION DEFECT</b>					
19a. DATE OF OPERATION <b>11/16/83</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>SEVERE AORTIC STENOSIS &amp; C.A.D.</b>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 14</b> , 19 <b>83</b> , to <b>Nov. 16</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>Nov. 16</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) not view the body after death.					
22b. SIGNATURE <b>A. Neimat, M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>Nov. 17, 1983</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMIR NEIMAT, M.D.</b>		22e. ADDRESS <b>10313 GEORGIA AV. SILVER SPRING MD 20902</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Nov. 21, 1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cem.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Springs Mont. Md.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 21 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Bauer</b>	

Unit of No.

1910 United Road 20740

1910 United Road 20740

1910 United Road 20740

1910 United Road 20740

1910 United Road 20740

1910 United Road 20740

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

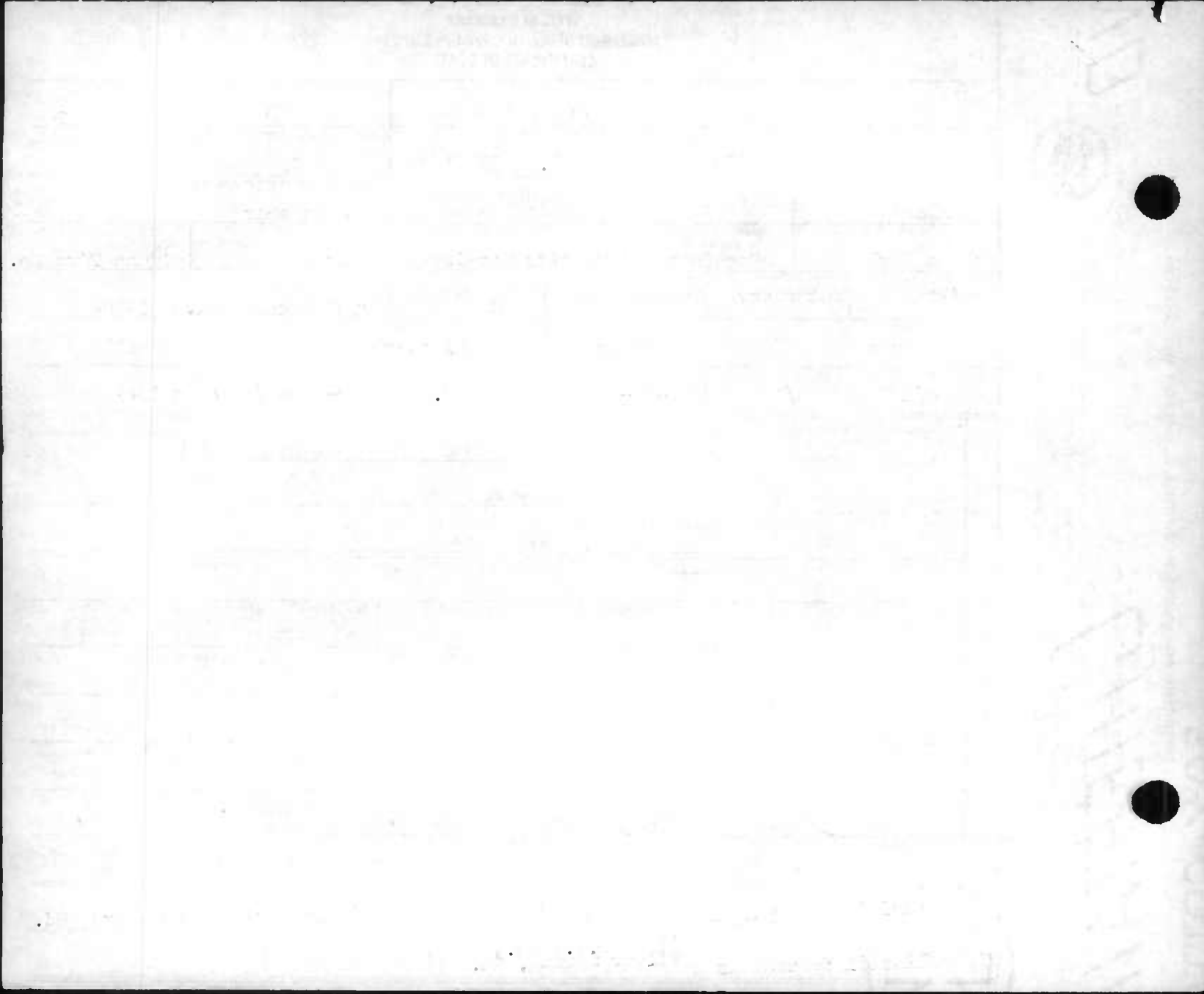
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30728

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) George Mutimer			2a. DATE OF DEATH MONTH DAY YEAR NOV 13, 1983			2b. HOUR 12 <sup>10</sup> A.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 17 1890		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) England		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Stidman Tire Co.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland Montgomery Silver Spring									
14. FATHER'S NAME FIRST MIDDLE LAST George Mutimer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Moralle		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
13a. STREET ADDRESS 13005 Autumn Drive		20904							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) N/A		17. INFORMANT George R. Mutimer-son- (same as 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4920 IMMEDIATE CAUSE (a) Bilateral lower lobe pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Emphysema DUE TO, OR AS A CONSEQUENCE OF (c) Malnutrition Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Nov. 11, 1983, to Nov. 13, 1983, that (I) (we) lost saw the deceased alive on Nov. 13, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Susan Voss, MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 11/13/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SUSAN VOSS, M.D.				22e. ADDRESS 1161 New Hampshire Ave. Silver Spring Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-15-83		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.			
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home				11800 N.H. Ave. Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR NOV 14 1983		25b. REGISTRAR'S SIGNATURE John J. Carver	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE GIVEN WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		3 0 7 2 9	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH	
FIRST MIDDLE LAST Myron Luther Myers		MONTH DAY YEAR HOUR <input checked="" type="checkbox"/> 11 3 83 818 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)
M	W	MONTH DAY YEAR 7-3-84	LAST BIRTHDAY 79 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	
Maryland		United States	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	
Gaithersburg		13320 Travillah Road	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Landscaper		A. Gude & Son	
13a. STATE		13b. COUNTY	
Maryland		Montgomery	
13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Gaithersburg		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS		Zip: 20878	
13320 Travillah Rd.			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
FIRST MIDDLE LAST Edward Myers		FIRST MIDDLE LAST Ellie Myers	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
No		577 20 9749	
17. INFORMANT		ADDRESS	
Bertha H. Myers		Wife Same as item 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART 1 DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) Gun Shot wound of Head.			
DUE TO, OR AS A CONSEQUENCE OF			
(b)			
DUE TO, OR AS A CONSEQUENCE OF			
(c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY?			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY	
		HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
		21f. LOCATION	
		CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE		TITLE (SPECIFY)	
John Tauber		Deputy MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT)		DATE SIGNED	
John Tauber		11-3-83	
ADDRESS		BETHESDA	
8218 Wisconsin Ave			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Burial		Nov 7, 1983	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Darnestown Presbyterian Church Cemetery		TOWN COUNTY STATE Darnestown, Maryland	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR	
ROBERT A. PUMPHREY FUNERAL HOMES, P.A. ROCKVILLE, MARYLAND		NOV 7 1983	
NAME		25b. REGISTRAR'S SIGNATURE	
		[Signature]	

(M)

QND M

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 7 3 0

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>SAPHONIA W. NAPIER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 22 1983</b>		2b. HOUR <b>12:31<sup>P</sup> M</b>
3. SEX <b>FEMALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>JULY 12 1929</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>TENNESSEE</b>	7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. <b>BALTIMORE CITY</b> OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>
13a. STATE <b>TENNESSEE</b>		13b. COUNTY <b>CARTER</b>	13c. CITY OR TOWN <b>ELIZABETHTON</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>GERALD MOORE</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>INA BELLE BREEDLOVE</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>408-80-5027</b>		17. INFORMANT ADDRESS <b>JAMES NAPIER, 405 CHURCH STREET, ELIZABETHTON, TN 37643</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

2028

IMMEDIATE CAUSE (a) **LYMPHOMA**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

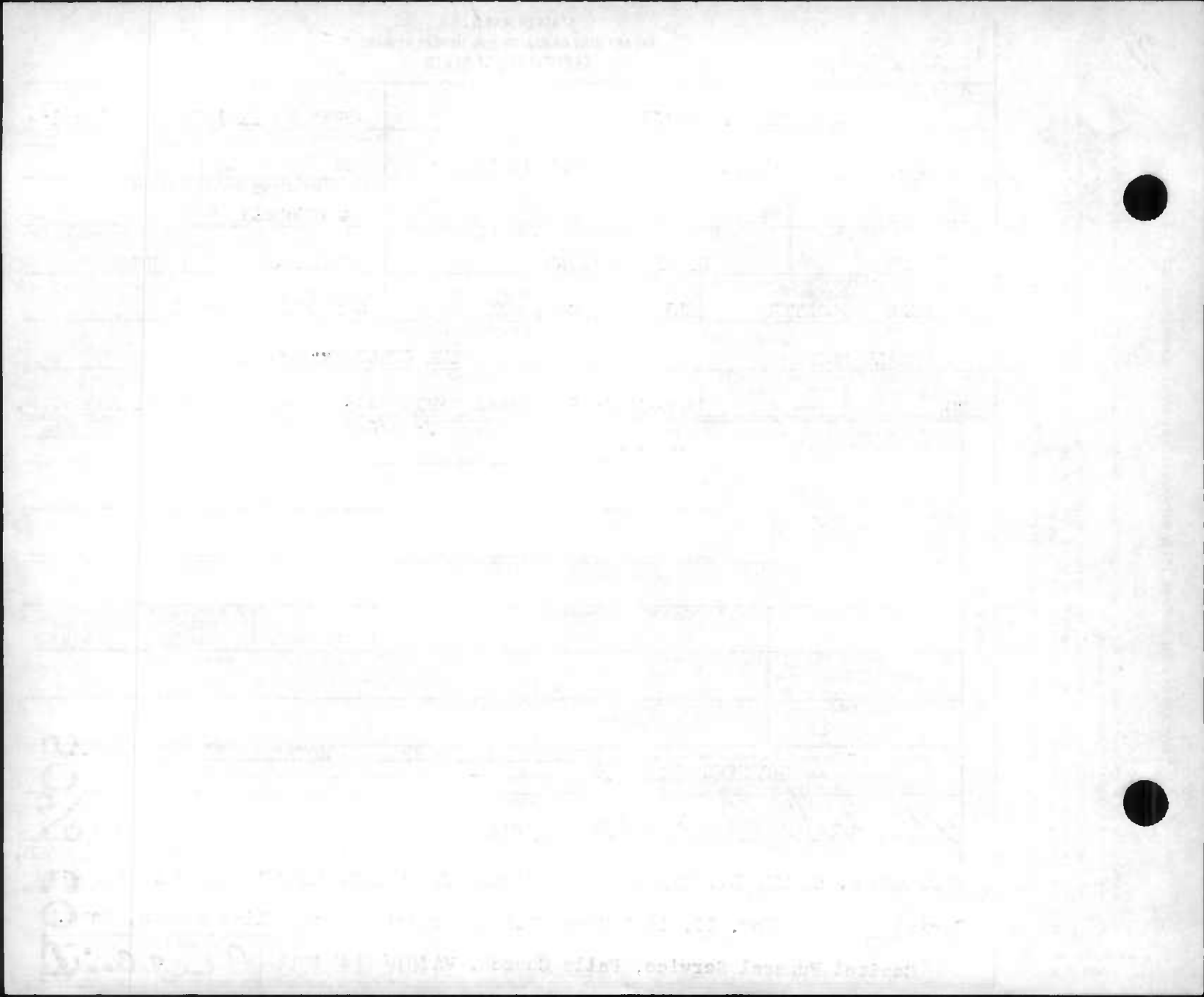
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 10 19 83</b> , to <b>NOVEMBER 22 19 83</b> , that (I/we) last saw the deceased alive on <b>NOVEMBER 22 19 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Michael D. Canty</i>	DEGREE <b>LT, MC, USNR M.D.</b>		22c. DATE SIGNED <b>23 NOV 83</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MICHAEL D. CANTY, LT, MC, USNR</b>	22e. ADDRESS <b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Nov. 25, 1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Happy Valley Memorial Park</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Elizabethton, Tenn.</b>
24. FUNERAL DIRECTOR NAME <b>Capitol Funeral Service, Falls Church, VA</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1983</b>	25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30731

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) IDA H. NASH			2a. DATE OF DEATH MONTH DAY YEAR Nov. 30 1983		2b. HOUR 5:30 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 17, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Czechoslovakia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery, MD.	
10. CITY OR TOWN OF DEATH Olney, MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Brooke Grove Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY -----	
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Sil. Spring	13e. STREET ADDRESS / ZIP CODE 15316 Pine Orchard Drive 20906	
14. FATHER'S NAME FIRST MIDDLE LAST Ludwig Brenner			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hermine Feldbauer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 578-44-6699		17. INFORMANT ADDRESS Bethesda, Md. David Abraham; 6201 Hollins Drive	

1. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Bowin Malignancy</u> 1919 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chondrosarcoma multiforme</u> (c) <u>Encephaloma</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)	
19a. DATE OF OPERATION May 1983	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Glioblastoma Multiforme
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) None
21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) No Injury	
21g. LOCATION CITY OR TOWN COUNTY STATE None	
22a. certify that (I) (this hospital) attended the deceased from 5-1-83 to 11-30-83, that (I) (we) lost saw the deceased alive on 11-30-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE Dr. B. G. MANEJWALA	22c. DATE SIGNED 11-30-83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. B. G. MANEJWALA	22e. ADDRESS 14201 Laurel Park Drive #102 Laurel MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/2/83	23c. NAME OF CEMETERY OR CREMATORY King David Mem. Gdn.	23d. LOCATION Falls Church; Fairfax, Va.
24. FUNERAL DIRECTOR NAME ADDRESS DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Maryland 20852		25a. DATE REC'D. BY REGISTRAR DEC 6 1983	25b. REGISTRAR'S SIGNATURE John J. Connel

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



THE UNIVERSITY OF CHICAGO  
LIBRARY

1911

THE UNIVERSITY OF CHICAGO  
LIBRARY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30732

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME  
(TYPE OR PRINT)

FIRST MIDDLE LAST  
Ruth M. Naylor

2a. DATE OF DEATH MONTH DAY YEAR  
11-23-83

2b. HOUR  
4<sup>10</sup> A.M.

3. SEX

Female

4. RACE

Caucasian

5. DATE OF BIRTH

Dec. 13, 1900

6. AGE (IN YEARS LAST BIRTHDAY)

82

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Montgomery

MD.

10. CITY OR TOWN OF DEATH

Wheaton

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Manor Care Wheaton

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Homemaker

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Montgomery

13c. CITY OR TOWN

Takoma Park

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

7051 Carroll Avenue 20912

14. FATHER'S NAME

Charles

MIDDLE

Hull

LAST

15. MOTHER'S MAIDEN NAME

Sara

MIDDLE

Roberts

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.

215-38-5994

17. INFORMANT

Niece  
Audrey Miller

ADDRESS

3238 Hewitt Avenue  
Silver Spring, Md. 2090618. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4292

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Pneumonia

(c) Cardiac disease

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ AT WORK NOT WHILE ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 9-2 19 83, to 11-22 19 83, that (I) (we) lost  
saw the deceased alive on 11-22-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Myron L. Lenkin

DEGREE

ATTENDING  
PHYSICIAN ☒MEDICAL  
DIRECTOR ☐STAFF  
PHYSICIAN ☐

22c. DATE SIGNED

11/23/83

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

MYRON L. LENKIN

22e. ADDRESS

2309 SHOREFIELD RD  
WHEATON, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

Nov. 26, 1983 Rockville Cemetery

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION CITY OR TOWN COUNTY STATE

Rockville Montgomery Md.

24. FUNERAL DIRECTOR NAME

Francis J. Collins

ADDRESS

500 University Blvd., W. Silver Spring, Md.

25a. DATE REC'D. BY REGISTRAR

DEC 2 1983

25b. REGISTRAR'S SIGNATURE

John J. Givich



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 7 3 3

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Charles Newman</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>November 5 1983</i>		2b. HOUR <i>6:55pm</i>	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>June 2, 1904</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Russia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>Russia</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>79</i>		
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County, MD</i>		
13a. STATE <i>Md.</i>		13b. CITY OR TOWN <i>Silver Spring</i>		13c. STREET ADDRESS <i>10110 New Hampshire Ave. 20903</i>		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>Unkn.</i>		16b. SOCIAL SECURITY NO. <i>577-26-9405A</i>		17. INFORMANT ADDRESS <i>Mr. Herman Newman 3231 S. Leisure Wor Silver Spring, Md. Blvd</i>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*4140*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov 5 80</i> to <i>Nov 5 83</i> , that (I) (we) last saw the deceased alive on <i>Nov 5 83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>[Signature]</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>		23b. DATE <i>11/6/83</i>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <i>Anatomy Board</i>				ADDRESS <i>Balto., Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>NOV 10 1983</i>	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



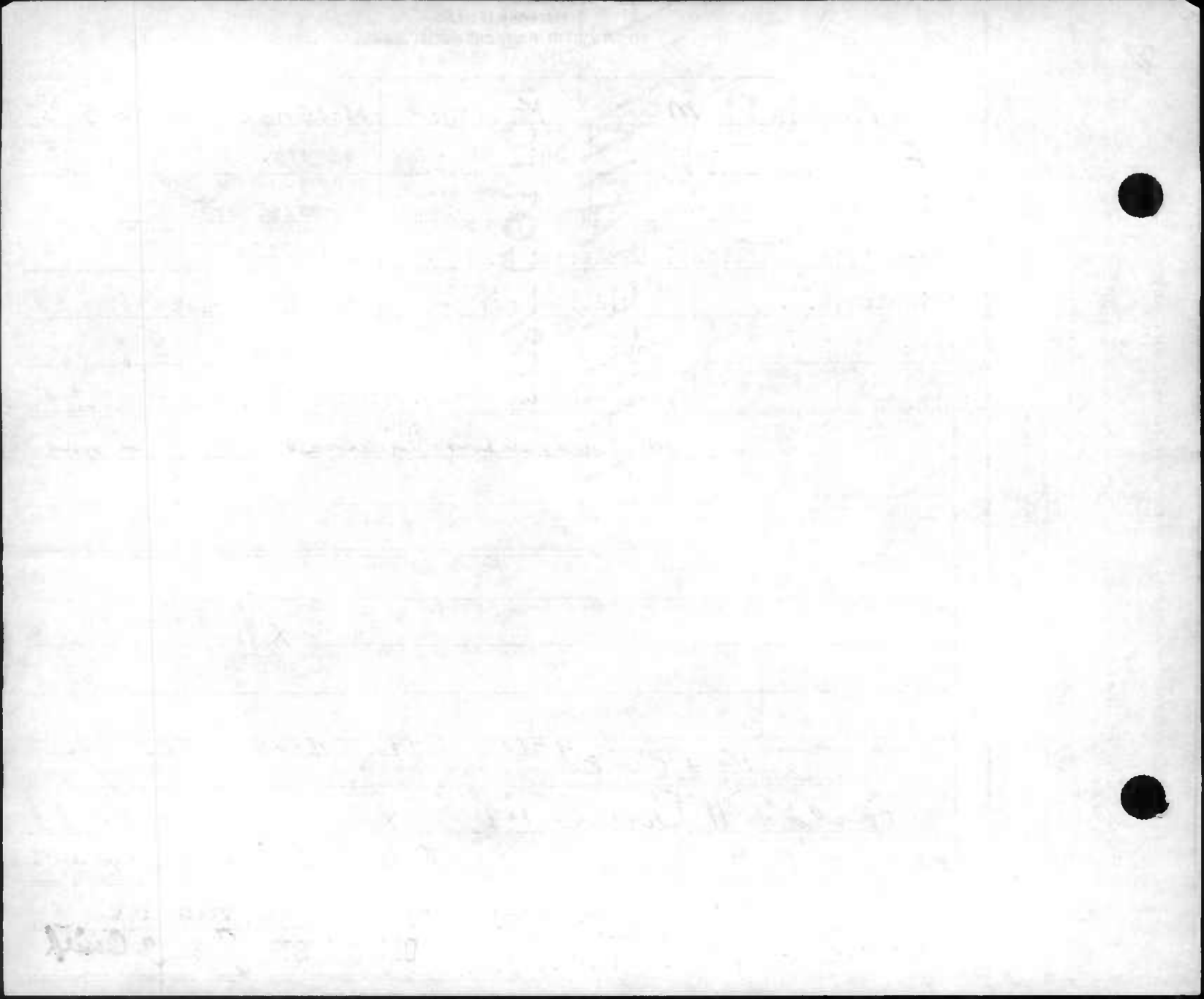
*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be made.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										30734			
1 - FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
FANNIE M NEWMAN								NOVEMBER		26-1983	5	30 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
F		Black		July 14, 1890		93 yrs.		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Virginia		U.S.A.				Montgomery.						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Rockville		National Lutheran Home		Housewife									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Washington, D.C.		N.E.				YES <input type="checkbox"/> NO <input type="checkbox"/>		220 'H' Street		99999			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
Isaac		Couch		Ford									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		3310 IMMEDIATE CAUSE (a)		alzheimer's Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		2 yrs					
DUE TO, OR AS A CONSEQUENCE OF		(b)											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
		P.M. 19											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION									
WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4-18, 19 77 to 11-26, 19 83, that (I) (we) lost saw the deceased alive on 11-24, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.													
22b. SIGNATURE		DEGREE		22c. DATE SIGNED									
Harold F. McCann		M.D.		11-26-83									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
HAROLD F. MCCANN		3355-16th St. NW WASH. D.C.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION							
Burial		11/30/83		Mt. Olivet Cem.		Washington, D.C.							
24. FUNERAL DIRECTOR		NAME		ADDRESS		25. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Hall Bros. Funeral Home				621 Fla. Ave., N.W. Wash., D.C.		DEC 01 1983		J. Conner					





3073

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIRIAM ANNA		MIDDLE NEWMAN		LAST NEWMAN		2a. DATE OF DEATH		MONTH 11	DAY 10	YEAR 88	2b. HOUR 4:50 PM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH April 4, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 66		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD											
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HEBREW HOME OF GREATER WASHINGTON										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY Oil Company			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9520 Duffer Way 20879	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg													
14. FATHER'S NAME FIRST Joseph MIDDLE Stein LAST Stein				15. MOTHER'S MAIDEN NAME FIRST Anna MIDDLE Stroman LAST Stroman													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 037-07-8396		17. INFORMANT Mrs. Elaine Miller										ADDRESS Same as No. 13			

<b>18 CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Acute Lymphocytic Leukemia</u>		
2040 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last	DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)

CERTIFICATION	Huntington's Chorea.			
	19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>

MEDICAL CERTIFICATE	21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
	21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that ~~the~~ (this hospital) attended the deceased from 4-5, 1982, to 11-10, 1983, that ~~the~~ (we) last saw the deceased alive on 11-10, 1983, and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above, ~~that~~ (we) (did) (did not) view the body after death.

27b. SIGNATURE R. Shah DEGREE MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ 27c. DATE SIGNED 11/10/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. H. SHAH MD	22e. ADDRESS 6105 Mantrose Road Rockville MD
--	--

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>11/13/1983</i>	23c. NAME OF CEMETERY OR CREMATORY <i>King David Memorial Garden</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Falls Church, Virginia</i>
---	--------------------------------	---	---

24. FUNERAL DIRECTOR	Donald M. Stein Hebrew Memorial F.H.	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
232 Carroll Street, N. W.	Washington, D. C.	NOV 16 1983	<i>James J. Connel</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove co-bonoposers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

BP\_\_\_\_\_

Nov 18 1900

RECEIVED NOV 18 1900

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM "PM" 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHM - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO.			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JANE A. NEWPORT</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11-5-83</b>		2b. HOUR <b>8:25P</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6-2-26</b>		6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>57</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>11-5-83</b>		2d. HOUR <b>8:25P</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b>				
10. CITY OR TOWN OF DEATH <b>Bethesda</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Potomac</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>1224 Willow Brook Dr 20854</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John McClelland</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>June McFadden</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>301-22 -8353</b>			17. INFORMANT ADDRESS <b>Richard T Newport. Same as item 13</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> 4140 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>Coronary arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <b>Chronic obstructive Pulmonary Disease</b>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <b>John Tamber</b>				TITLE (SPECIFY) <b>M.D.</b>				MEDICAL EXAMINER <b>Bethesda</b>				DATE SIGNED <b>11-5-83</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>John Tamber</b>				ADDRESS <b>8218 Wisconsin Ave.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>11/9/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Memorial Park. Cem.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rockville Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., D.C.</b>													
DATE REC'D BY REGISTRAR <b>NOV 14 1983</b>													
REGISTRAR'S SIGNATURE <b>John J. Connelley</b>													

MEDICAL CERTIFICATION

x



*Handwritten signature*

NOV 14 1988

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

30737

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST CALLA Gillard		MIDDLE Nelson		LAST		2a. DATE KNOWN OF DEATH ESTI- MATED		MONTH 11		DAY 2		YEAR 1983		2b. HOUR A M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 30 9 48		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH 11		DAY 2		YEAR 1983		2d. HOUR 7 A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota				7b. CITIZEN OF WHAT COUNTRY? United States				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY County MD									
10. CITY OR TOWN OF DEATH BETHESDA				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5524 CHARLES ST								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher				12b. KIND OF BUSINESS OR INDUSTRY Music					
13a. STATE MD				13b. COUNTY MONTGOMERY				13c. CITY OR TOWN BETHESDA				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 20814 5524 CHARLES ST					
14. FATHER'S NAME FIRST MIDDLE LAST Charles Gillard				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Knapp				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 503 32 6831A				17. INFORMANT Phillip G. Nelson (son) see #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. } DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR D</u> } DUE TO, OR AS A CONSEQUENCE OF (c) _____ } APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>ACUTE</u> <u>YRS</u>																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11 2 1983				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) FOUND DEAD IN BOB													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5524 CHARLES ST BETHESDA MONTGOMERY MD													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquest <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE [Signature] EXAMINER'S NAME (TYPE OR PRINT) James M. May Jr.				M.D. [Signature] TITLE (SPECIFY) [Signature] ADDRESS 6700 Wisconsin Ave Bethesda MD				DATE SIGNED 11/2/83 20814 5524 CHARLES ST													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE Nov. 2				23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria				23d. LOCATION CITY OR TOWN COUNTY STATE Virginia									
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland				25a. DATE REC'D. BY REGISTRAR NOV 4 1983				25b. REGISTRAR'S SIGNATURE [Signature]													

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

24

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical technician must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Lucy ANN Nicholson</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>NOV 10 83</b>	
3. SEX <b>Female.</b>		4. RACE <b>White.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>SEPT. 19-1899</b>	
6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASH. D.C.</b>		6b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. CITY OR TOWN OF DEATH <b>Kensington</b>		7b. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>KENSINGTON GARDENS Nursing CTR.</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD.</b>	
10. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>MONT.</b> 13c. CITY OR TOWN <b>TAKOMA PARK</b>		11. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
14. FATHER'S NAME FIRST <b>ROBERT</b> MIDDLE <b>J.</b> LAST <b>NORTON</b>		15. MOTHER'S MAIDEN NAME FIRST <b>MARION E.</b> MIDDLE <b>NORTON</b> LAST		13d. STREET ADDRESS <b>20912 6410 WESTMORELAND AVE.</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. <b>217-32-0290</b>		17. INFORMANT ADDRESS <b>SAME AS</b> <b>MARSHALL E. NICHOLSON. ITEMS 13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4254 Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary artery</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Atherosclerosis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>months</b> <b>years</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY OR ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 19 78</b> to <b>11/10/83</b> , that (I) (we) last saw the deceased alive on <b>11/2/83</b> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) not view the body after death.					
22b. SIGNATURE <b>Thos G. Ward</b>		22c. DATE SIGNED <b>11/10/83</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thos G. WARD</b>	
22e. ADDRESS <b>6116 Robinwood, Bethesda Md</b>		22f. DATE REC'D. BY REGISTRAR		22g. REGISTRAR'S SIGNATURE <b>John J. Carver</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial.</b>		23b. DATE <b>11/12/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GEORGE WASHINGTON ADELPHI</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>P.G. 208 MD</b>		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR <b>Takoma Funeral Home.</b> <b>54 Carroll St. N. W. D.</b>					

100-100-100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or medical examiner's assistant must be notified.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30739

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST MARK ANGE NOCELLA			MONTH DAY YEAR Nov 12 1982			1 58 AM		
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 11 - 21 1900	6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canada	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Mont. MD.					
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY AT HOME		
13a. STATE MD	13b. COUNTY Mont.	13c. CITY OR TOWN Kensington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1807 - Stella Ct 20895				
14. FATHER'S NAME FIRST MIDDLE LAST FLAVIN EMILE HOUE			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GRAZIELLA - GATINEAU					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-46-3821		17. INFORMANT ADDRESS NANCY J. WHITE, 820 FAIRWAY AVE. CATONSVILLE, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4429 IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>POSSIBLE RUPTURED ANEURYSM</u> (c) <u>POSSIBLE RUPTURED ANEURYSM</u> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from <u>11 NOV 82</u> to <u>12 NOV 82</u> , that (I) (we) last saw the deceased alive on <u>11 NOV 82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.								
22b. SIGNATURE <u>[Signature]</u>			22c. DATE SIGNED 12/Nov/82			22d. PHYSICIAN'S NAME (TYPE OR PRINT) DEGREE MD		
22e. ADDRESS			22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL		23b. DATE 11/14/83		23c. NAME OF CEMETERY OR CREMATORY GEORGETOWN UNIV. MENSCH.		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D.C.		
24. FUNERAL DIRECTOR NAME COLUMBIA MORTUARY SERVICES, WASH., D.C.				25a. DATE REC'D. BY REGISTRAR NOV 18 1983		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

BP



NOV 18 1953  
J. H. G. G. G.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. OBTAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		XX MONTH DAY YEAR		2b. HOUR	
Earl		Warren		Nuckols				11-27		1983		M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) (LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		2d. HOUR		
Male	Cauca	March 6, 1958		25 YRS.					11-27 1983		5:56 a.m.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		United States				Montgomery County, MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Rockville		Shady Grove Adventist Hospital		Carpenter		Construction							
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
Maryland		Montgomery		Rockville				10719 Boswell Lane		20854			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Earl		Carolyn		Atwell									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No		215 72 7532		Wife		Deborah L. Nuckols		Same as item 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Blunt Trauma to Chest</u> 8150 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:40xx 11-27 1983		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) driver in auto/fixed object impact									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 28 at Duffie Mill Rd., Poolesville, Montgomery Co., Md.									
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED									
Dennis F. Smyth, M.D.		Assistant		11-27-83									
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS											
Dennis F. Smyth, M.D.		111 Penn Street		Balt. Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		Nov. 30, 1983		Parklawn Memorial		Rockville, Maryland							
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND		NOV 28 1983		John J. Conner									

STATE OF MARYLAND  
COUNTY OF BALTIMORE  
Circuit Court for Baltimore City

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30741

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Edna A Oakley</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-23-83</b>		2b. HOUR <b>7:40 A.M.</b>	
3. SEX <b>F</b>		4. RACE <b>N 2</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 7 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>David Wilson Poole</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Harriet E Orr</b>		16. ADDRESS <b>4824 Eades St</b>		17. INFORMANT <b>Mary Jane Nutter</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>None</b>		17. ADDRESS <b>4824 Eades St</b>		18. ADDRESS <b>Rockville, Md 20853</b>

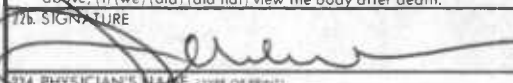
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

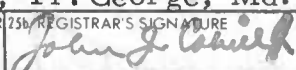
4140  
IMMEDIATE CAUSE (a) Cardiac arrest  
DUE TO, OR AS A CONSEQUENCE OF  
(b) Coronary and generalized  
DUE TO, OR AS A CONSEQUENCE OF  
(c) arteriosclerosis

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 1</u> , 19 <u>83</u> , to <u>Nov 23</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>Nov 22</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 		DEGREE		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11/23/83</u>	
22a. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John J. Merendino MD</b>		22b. ADDRESS <b>11620 Kemp Mill Rd, Sil. Spg. Md.</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>11-25-1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Pr. George, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>W. W. Chambers Co., Inc.</b>		ADDRESS <b>Silver Spring, Md</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 30 1983</b>		25b. REGISTRAR'S SIGNATURE 	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For use of the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



578

200%

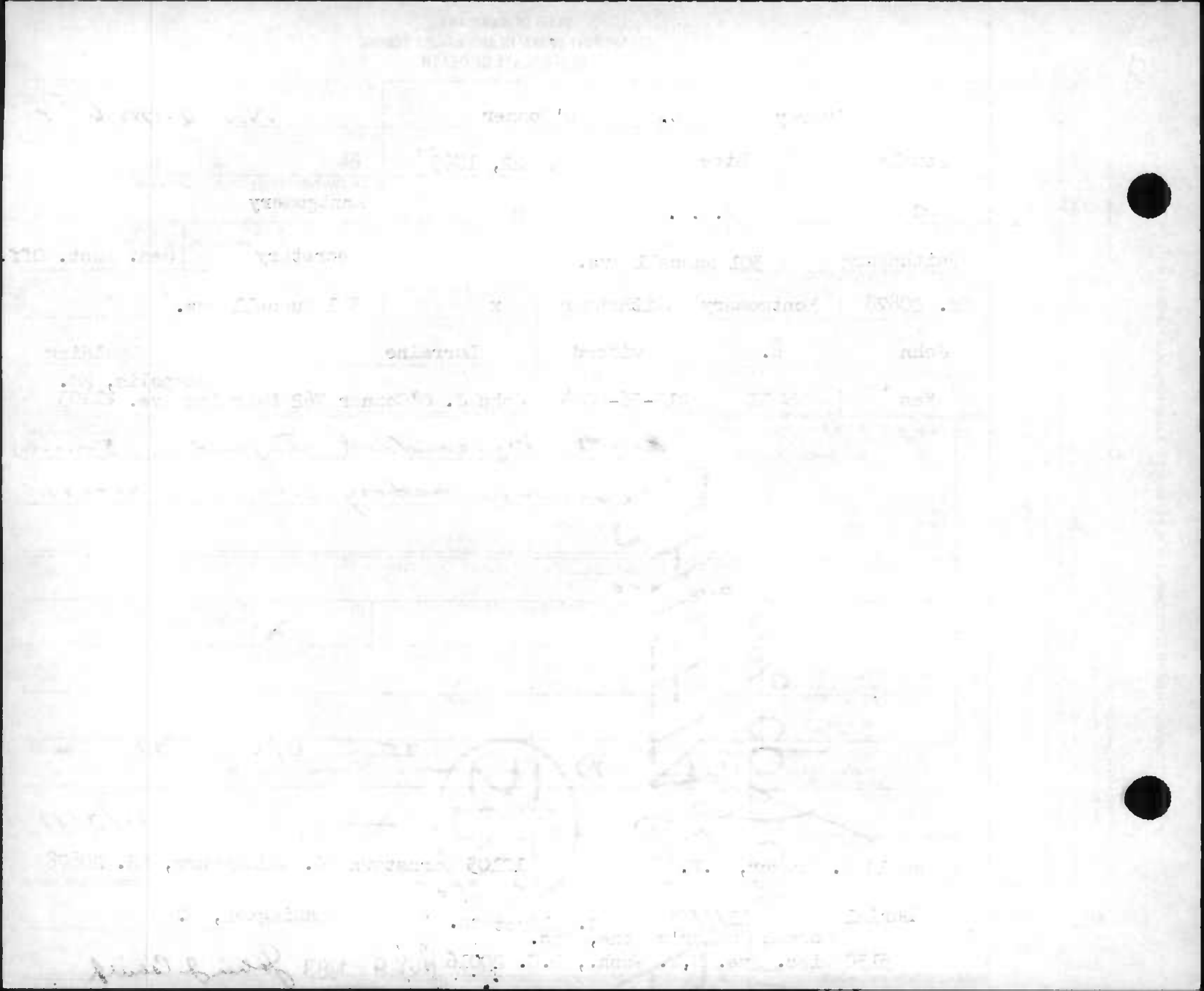
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 30742			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST Audrey C. O'Conner				2b. HOUR 6 <sup>15</sup> P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug 22, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Gaithsburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 301 Russell Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Gen. Acct. Off.	
13a. STATE Md. 20878		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithsburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John W. Twiford		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lorraine Spalding		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 213-56-0044	
17. INFORMANT ADDRESS John J. O'Connor 762 Fairview Ave. Annapolis, Md. 21403		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction 5 minutes 4100 DUE TO, OR AS A CONSEQUENCE OF (b) coronary artery disease YEARS DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) old eye		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. SIGNATURE (I) (this hospital) attended the deceased from 19 75 to 11/3 19 82, that (I) (we) lost saw the deceased alive on 11/1 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE (I) (this hospital) attended the deceased from 19 75 to 11/3 19 82, that (I) (we) lost saw the deceased alive on 11/1 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22c. DATE SIGNED 11/3/82		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ronald E. Gregor, M.D.		22e. ADDRESS 12105 Darnstown Rd. Gaithsburg, Md. 20878	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/5/83		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, DC	
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc.		24b. DATE REC'D. BY REGISTRAR NOV 9 1983		24c. REGISTRAR'S SIGNATURE John J. O'Connor		24d. ADDRESS 5130 Wisc. Ave. N.W. Wash., D.C. 20016	

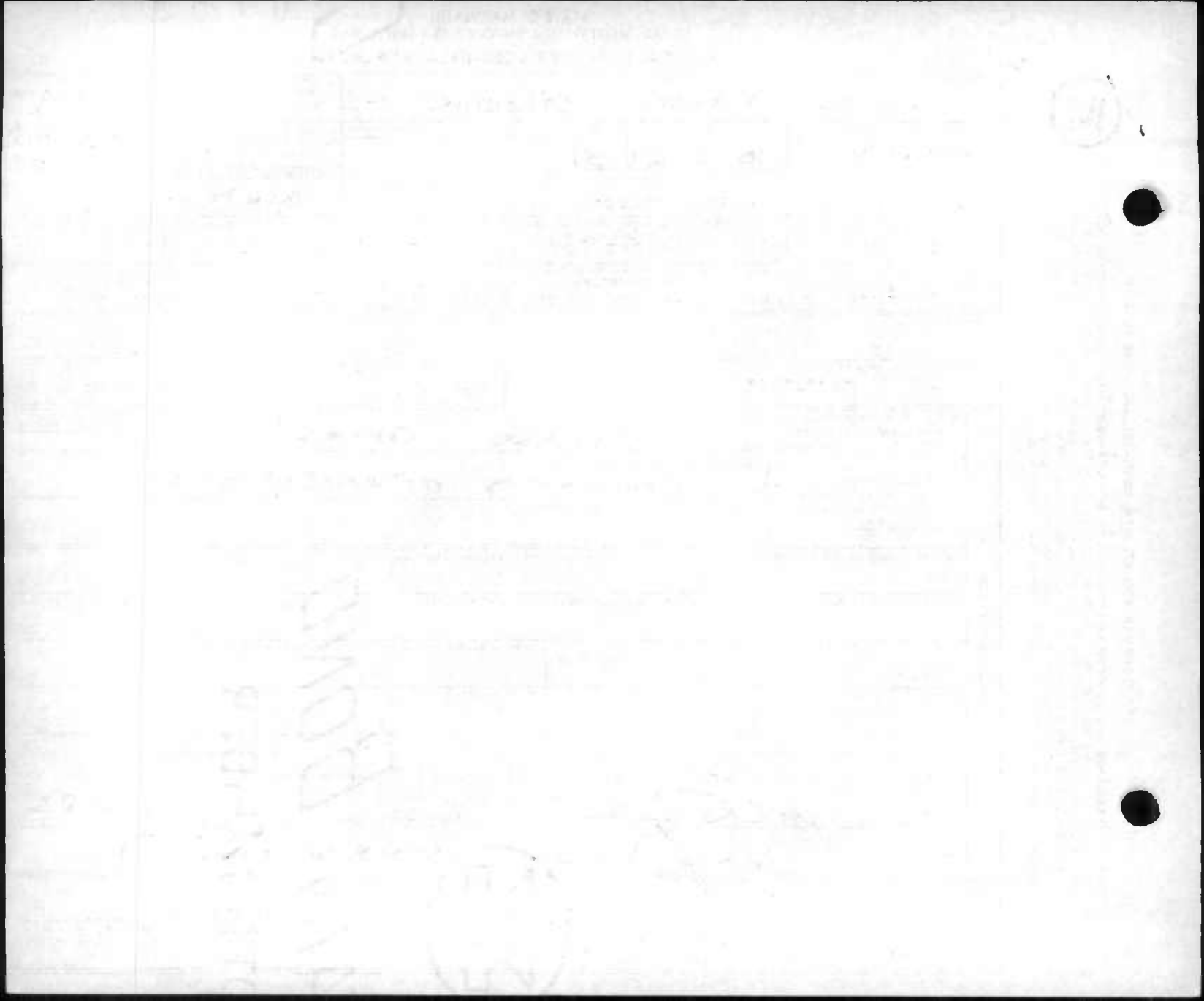




TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. GIVE PAGE 5 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

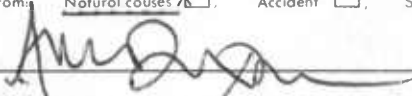
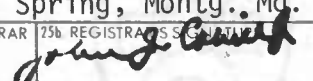
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 30743			
1. DECEASED NAME (TYPE OR PRINT) <b>James Patrick O'Conner Jr.</b>										2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>11-4-83</b>		2b. HOUR <b>10:00 AM</b>	
3. SEX <b>male</b>		4. RACE <b>W</b>		5. DATE OF BIRTH (MONTH DAY YEAR) <b>10-3-24</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD <b>11-4-83</b>		2d. HOUR <b>9:15 PM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington DC</b>				7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4525 Windsor Lane Bethesda Md</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Chief Petty Officer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Navy</b>	
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>California</b> 13b. COUNTY <b>Orange</b> 13c. CITY OR TOWN <b>Westminster</b>										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>92683 =5572 Amador Avenue</b>	
14. FATHER'S NAME (FIRST MIDDLE LAST) <b>James Patrick O'Conner</b>						15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>Mary Dent</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>1942-1963</b>		17. INFORMANT <b>Wife</b> ADDRESS <b>Ruby F. O'Conner Same as item 13</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4140</b> IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>coronary arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <b>John Tauber</b>				TITLE (SPECIFY) <b>Deputy</b> M.D.				MEDICAL EXAMINER <b>John Tauber</b> DATE <b>11-4-83</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>John Tauber</b>				ADDRESS <b>8218 Wisconsin Ave</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Nov. 9, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westminster Memorial Park</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Westminster, CA.</b>			
24. FUNERAL DIRECTOR NAME <b>ROBERT A. RUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 7 1983</b>				25b. REGISTRAR'S SIGNATURE <b>John J. Labadie</b>			

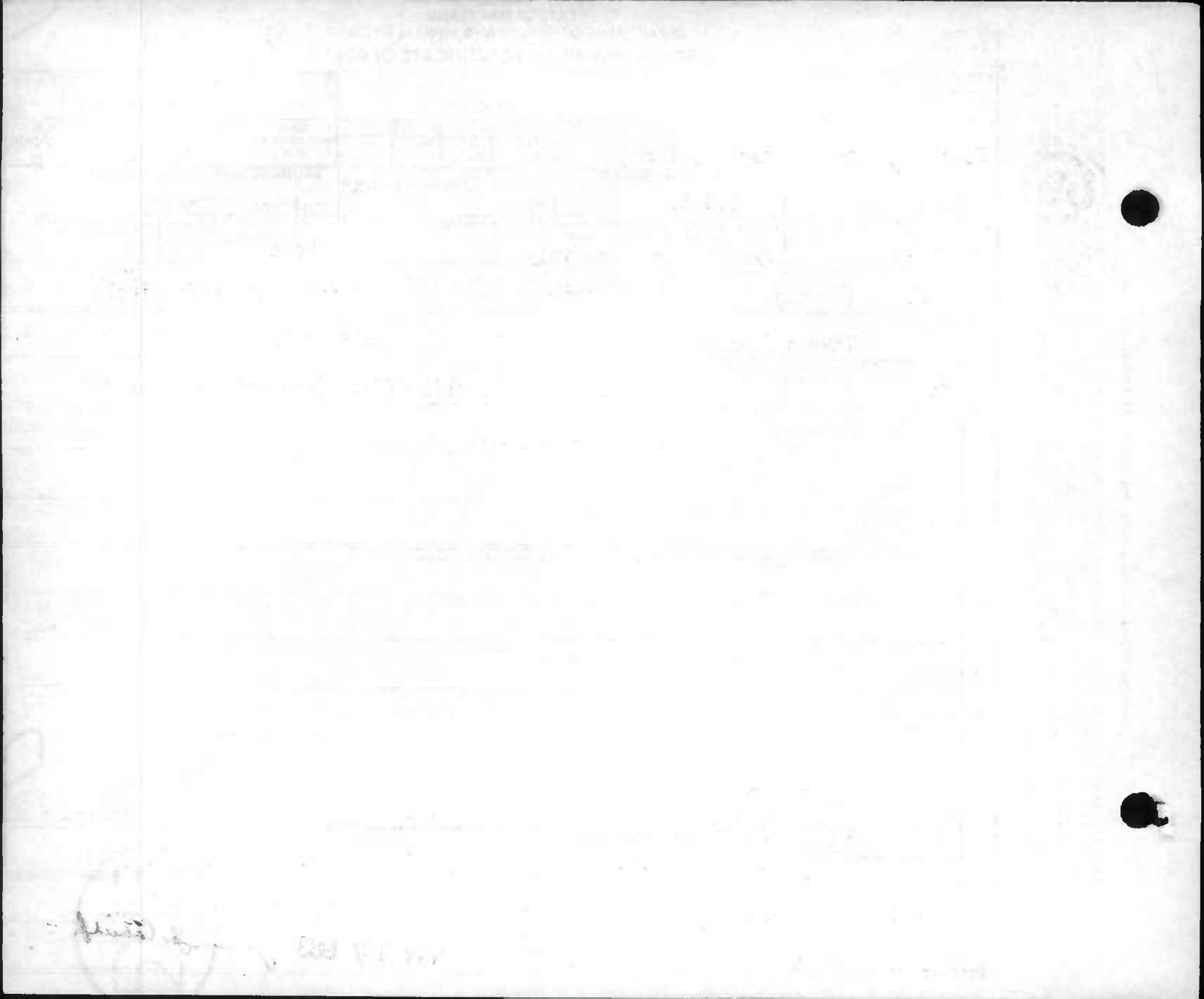


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										3 0 7 4 4 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>KEYONA OFFUTT</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11 12 1983</b>		2b. HOUR M <b>9:04</b>			
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 6, 1983</b>	6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN. <b>3 6</b>	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>11 12 1983</b>		7d. HOUR P M <b>9:04</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash. D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Hospital</b>			
12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12b. STATE <b>Md.</b>		12c. CITY OR TOWN <b>Montg.</b>		12d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		12e. STREET ADDRESS <b>18455 Lost Knife Circle</b>		12f. ZIP CODE <b>20877</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thyrus Seacry</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Leslie Offutt</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>					
16b. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT ADDRESS <b>Leslie Offutt (Mother) same as #13</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sudden Infant Death Syndrome</b> 7980 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. <b>Assistant</b> MEDICAL EXAMINER						DATE SIGNED <b>11-13-83</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>		ADDRESS <b>111 Penn St., Balto., Md. 21201</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-16-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring, Montg.. Md.</b>					
24. FUNERAL DIRECTOR NAME <b>George R. Snowden</b>		ADDRESS <b>246 N. Washington St. Rockville, Md. 20850</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 17 1983</b>		25b. REGISTRAR'S SIGNATURE 					



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30745

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Clarence Woodrow Oliver, Sr.</b> <i>CLARENCE WOODROW OLIVER</i>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 1, 1983</b> <i>11 1 83</i>		2b. HOUR <b>6:20 AM</b>		
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 16, 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>72</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired/Cab Driver</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Cab Co.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>D. C.</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Louis Murray Oliver</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ether Doggett</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>223-16-5987</b>	
17. INFORMANT <b>3539 Holmead Place, NW; Wash. DC</b>		18. INFORMANT'S NAME <b>Ethel Josephine Pulliam Oliver (wife)</b>		19. INFORMANT'S ADDRESS <b>3539 Holmead Place, NW; Wash. DC</b>		20. INFORMANT'S PHONE NO. <b>99499</b>	

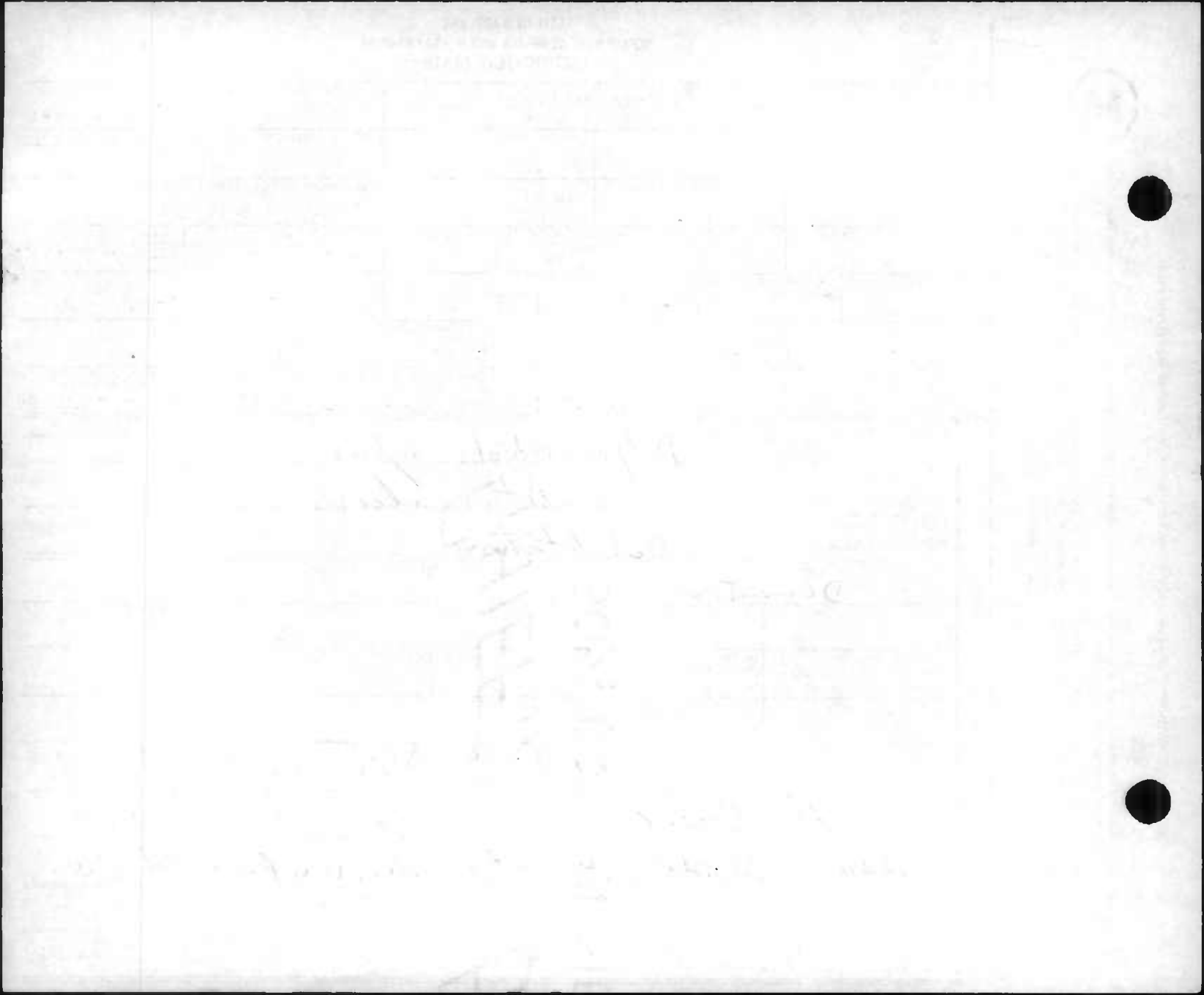
## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Polymicrobial sepsis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Dementia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Debilitation</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b) <b>Dementia</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>9-24-83</b> to <b>11-1-83</b> , that (I) (we) last saw the deceased alive on <b>10-31-83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>H. Bahar</b>		DEGREE		22c. DATE SIGNED <b>11-1-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HADI BAHAR M.D.</b>		22e. ADDRESS <b>8218 Wisconsin Ave. Beth Md.</b>		22f. DATE REC'D. BY REGISTRAR	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/5/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Memorial</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Landover, P.G. Co., Maryland</b>		24. FUNERAL DIRECTOR NAME <b>LATNEY's Funeral Home</b> <b>3831 Georgia Avenue, NW; Washington, DC</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 7 1983</b>	
25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30746

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>TEAR Yub-Kum ON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-30-83</b>		2b. HOUR <b>1800<sup>M</sup></b>		
3. SEX <b>Female</b>		4. RACE <b>Oriental</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 14 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>86</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>China</b>		7b. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. <b>BALTIMORE CITY</b> OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SHADY GROVE ADVENTIST</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>D. C.</b>		13b. COUNTY <b>N/A</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>On-Yuen Dear</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown Quan</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>577-84-3658</b>	
17. INFORMANT <b>Daughter</b>		ADDRESS <b>916 Crest Park Drive</b>		18. REBECCA J. WONG <b>Silver Spring, Md. 20903</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>respiratory insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>cervical cord compression</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>years</b>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 

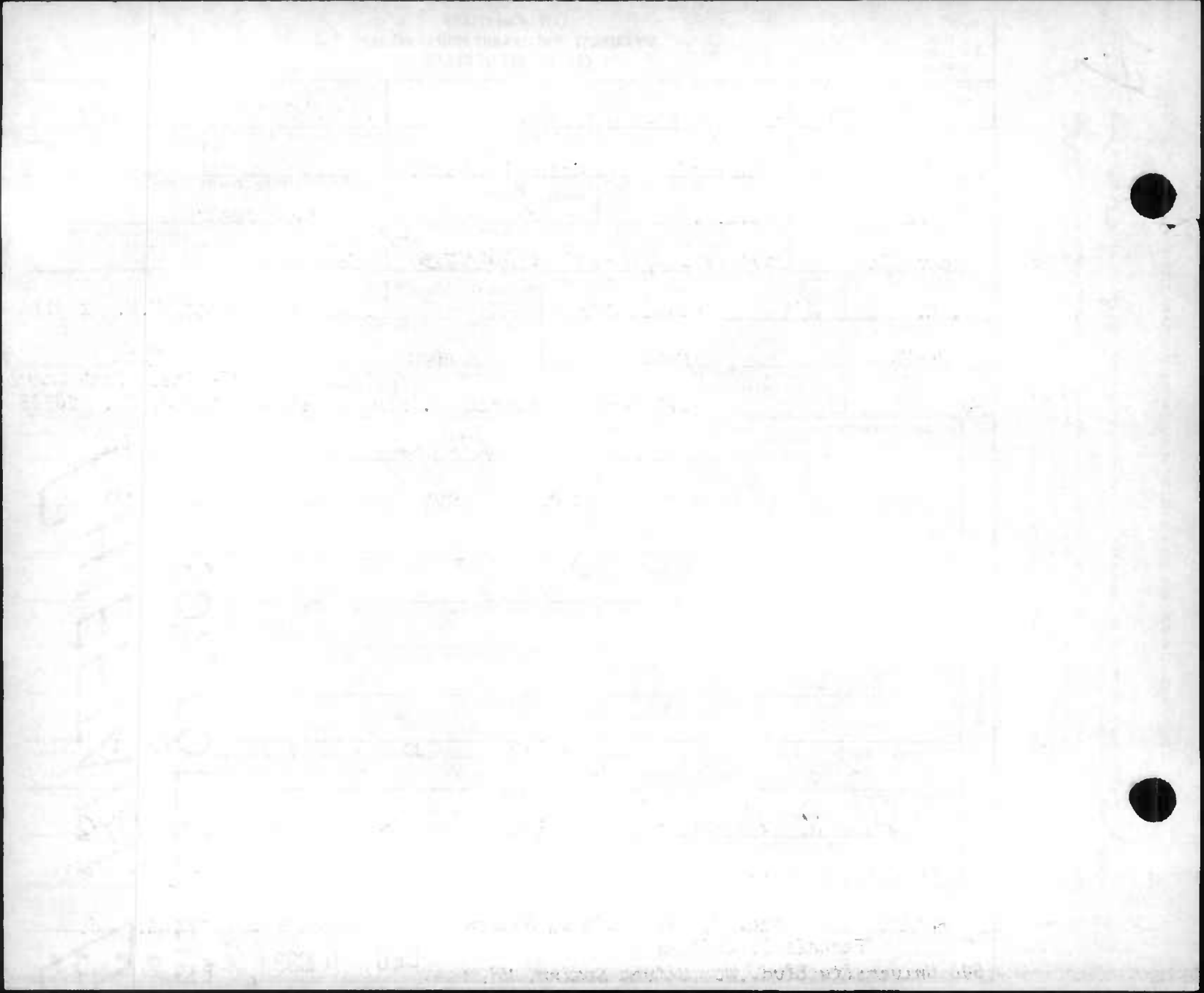
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11/29</b> , 19 <b>83</b> , to <b>11/30</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>11/30</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>John R. Melnick</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/30/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John R. Melnick</b>		22e. ADDRESS <b>16220 Frederick Road - Gaithersburg, Md. 20878</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec. 3, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Mont. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b>		ADDRESS <b>500 University Blvd., W. Silver Spring, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 6 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carish</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and a report obtained.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										30747			
1. FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (FIRST MIDDLE LAST) <b>Mary Alta O'Neill</b>										2a. DATE OF DEATH (MONTH DAY YEAR) <b>11 5 1983</b>		2b. HOUR <b>12:15A<sub>M</sub></b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH (MONTH DAY YEAR) <b>Sept. 8 1920</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>63</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington D. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD</b>							
10 CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Residence</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>					
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>13025 Cleveland Drive 20850</b>					
14 FATHER'S NAME (FIRST MIDDLE LAST) <b>John Joseph Reed</b>		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>Clara Thorne</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>							
		16b. SOCIAL SECURITY NO. <b>577-28-9086</b>		17. INFORMANT <b>Allen J. O'Neill</b>		18025 Cleveland Drive <b>Rockville, Md. 20850</b>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatous</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Adenocarcinoma of the Lung</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 mos</b> <b>11 mos</b>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>110</b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from above, (II) (myself) (did not) view the body after death, to <b>11/5/83</b> , to <b>11/5/83</b> , that (I) (we) lost													
22b. SIGNATURE <b>Robert C. Macon</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/5/83</b>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert C. Macon</b>				22e. ADDRESS <b>809 Viers Mill Rd. Rockville, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/8/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rockville Montgomery Md.</b>							
24 FUNERAL DIRECTOR NAME <b>Tyson Wheeler Funeral Home, Inc.</b>				1331 Rockville Pike Rockville, Md. 20852		NOV 10 1983		REGISTRAR'S SIGNATURE <b>John J. Connel</b>					

MEDICAL CERTIFICATION

The  $\text{CO}_2$  level

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be retained by the funeral director. Page 3 should be retained by the funeral director after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30748

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>JAMES RICHARD PARKS JR.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 10, 1983</b>			2b. HOUR <b>2:45 p.m.</b>						
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 22, 1983</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>05 18</b>		IF UNDER 1 YEAR IF UNDER 24 HRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. <b>BALTIMORE CITY OR</b> COUNTY OF DEATH <b>MONTGOMERY COUNTY, MD.</b>						
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL BETHESDA</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>N/a</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>NEW HAMPSHIRE</b>			13b. COUNTY <b>COOS</b>		13c. CITY OR TOWN <b>LANCASTER</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>97 SUMMER Street 03584</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES RICHARD PARKS Sr.</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANGELE MARIE PELLETIER</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>None</b>		
17. INFORMANT <b>James Richard Parks Sr. Father</b>			Address <b>97 SUMMER, LANCASTER, NH 03584</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>7855 IMMEDIATE CAUSE (a) HEMORRHAGIC SHOCK</b>												
DUE TO, OR AS A CONSEQUENCE OF (b) _____												
DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>MAY 22, 1983</b> to <b>NOVEMBER 10, 1983</b> that (I) (we) lost saw the deceased alive on <b>NOVEMBER 10, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>LT. MC</b>			DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>11 Nov 83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LT. MARGARET KOZEL, MC, USN</b>			22e. ADDRESS <b>NAVAL HOSPITAL BETHESDA</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Nov 15, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington Virginia</b>				
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey</b>			ADDRESS <b>Funeral Homes, P.A., Bethesda, Maryland</b>			25a. DATE REC'D. BY REGISTRAR <b>NOV 16 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>				

MEDICAL CERTIFICATION

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 7 4 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>John S. Patterson</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>11</b> YEAR <b>83</b>			2b. HOUR <b>1119</b> A.M.					
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>July</b> DAY <b>26</b> YEAR <b>1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ill.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Commissioner</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Fed. Gov't.</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Gaithersburg</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>9313 Haymarket Place 20879</b>					
14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b>Fremont</b> LAST <b>Patterson</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Margaret</b> MIDDLE <b></b> LAST <b>Miller</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b> (IF YES, GIVE WAR OR DATES) <b>WWII</b>				16b. SOCIAL SECURITY NO. <b>334-03-4002</b>		17. INFORMANT ADDRESS <b>Alma G. Patterson. Same as item 13.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured Aneurysm - abdominal</b> <b>4413</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>severe atherosclerotic CARDIOVASCULAR ds</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>pneumonia</b>											
19a. DATE OF OPERATION <b>NIA</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. <del>Physician</del> (this hospital) attended the deceased from <b>9-29-83</b> 19 <b>83</b> , to <b>11-11</b> 19 <b>83</b> , that (we) last saw the deceased alive on <b>11-11</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Jeffrey Witte</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/11/1983</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jeffrey Witte</b>						22e. ADDRESS <b>9715 Medical Cen. Dr., Rockville, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/15/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>				23d. LOCATION CITY OR TOWN <b>Arlington</b> COUNTY <b>Virginia</b> STATE <b></b>			
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons Inc.</b> <b>5130 Wisc. Ave., N.W. Wash., D.C.</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 17 1983</b> 25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>					

MEDICAL CERTIFICATION

227-228

X

• 11 •

Kindly send 1000 5/10/10

• 2010 •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30750

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Dorothy Ann Paxton</b>			2a. DATE OF DEATH MONTH <b>November</b> DAY <b>26</b> YEAR <b>1983</b>		2b. HOUR <b>9:50</b> A <b>M</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>January</b> DAY <b>27</b> YEAR <b>1931</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>52</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Illinois</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NIH Clinical Center, Bethesda, Md.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sales</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Sears &amp; Roebuck</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>Indiana</b>	13b. COUNTY <b>n/a</b>	13c. CITY OR TOWN <b>Hobart</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>1210 S. Decatur</b> <b>99999</b> <b>46342</b>	
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>Zajac</b> LAST <b>John</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Victoria</b> MIDDLE <b>Janik</b> LAST <b>Janik</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>346-24-0300</b>		17. INFORMANT ADDRESS <b>PO Box 54 Valparaiso, Ind.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1749</b> IMMEDIATE CAUSE (a) <b>Gastrointestinal hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Bilateral hemorrhage pneumonitis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Metastatic breast cancer</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 6</b> , 19 <b>83</b> , to <b>November 26</b> , 19 <b>83</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>November 26</b> , 19 <b>83</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (not) view the body after death.					
22b. SIGNATURE <b>Neil Caporaso</b>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>NEIL CAPORASO MD.</b>		22e. ADDRESS <b>National Institutes of Health Clinical Center, Bethesda, Md. 20205</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Nov 30 1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calumet Park Cemetery</b>	23d. LOCATION CITY OR TOWN <b>Merrillville, Indiana</b> STATE		
24. FUNERAL DIRECTOR NAME <b>Carol L. Hyman</b> ADDRESS <b>CAPITOL FUNERAL SERVICE - Falls Church, Va.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 01 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>	

MEDICAL CERTIFICATION

79

999999

UNITED STATES GOVERNMENT  
DEPARTMENT OF COMMERCE  
BUREAU OF STANDARDS



U.S.U.

100% COTTON

100% COTTON



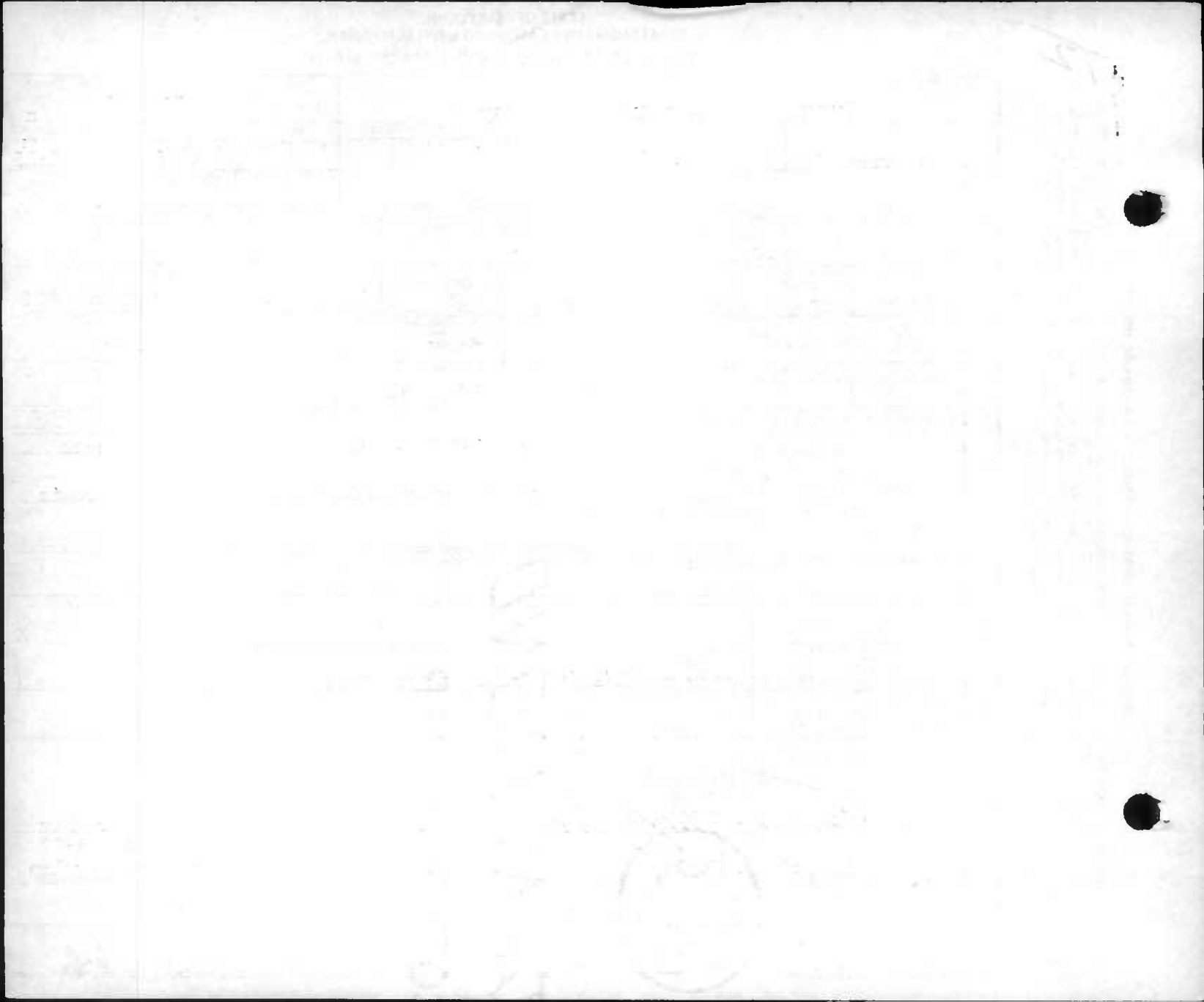


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (1))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 30751	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Grace Lenore Payne							2a. DATE KNOWN OF DEATH ESTIMATED November 19, 1983		2b. HOUR a.m.		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 2, 1901		6. AGE (IN YEARS) (LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD November 19, 1983	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Oklahoma		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County Maryland MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10250 Westlake Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS (20817) 10250 Westlake Drive #612			
14. FATHER'S NAME FIRST MIDDLE LAST Edward Patrick Magee				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Park							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 553-30-7820		17. INFORMANT 6745 Surreywood Ln. Elizabeth P. Hansen Bethesda, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Coronary Arteriosclerosis (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH. Acute Chronic											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR Early pm 11/19/83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Collapsed on Commode					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. Dept.				DATE SIGNED November 19, 1983			
EXAMINER'S NAME (TYPE OR PRINT) Francis C. Mayle				ADDRESS 8200 Wisconsin Ave Bethesda, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 1, 1983		23c. NAME OF CEMETERY OR CREMATORY Mulvane Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Mulvane, Kansas					
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland 20814				25a. DATE REC'D. BY REGISTRAR NOV 23 1983		25b. REGISTRAR'S SIGNATURE John J. Connel					

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be notified of once.

BH

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30752

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARION HELENE PEAR</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 14, 1983</b>			2b. HOUR MIN. <b>6:20 A</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 30, 1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>62</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Mass.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE CLINICAL CENTER, NIH</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>BETHESDA</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Leo Kopel</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hilda Cohen</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>032-14-2624</b>	
17. INFORMANT ADDRESS <b>SAME AS ABOVE</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GASTROINTESTINAL BLEEDING</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>OVARIAN CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>BOWEL OBSTRUCTION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>1830</b>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b> <b>3 YEARS</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>BOWEL OBSTRUCTION</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>September 30, 1983</b> , to <b>November 14, 1983</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>November 14, 1983</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death.							
22b. SIGNATURE <b>Eric J. Seifter</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>Nov. 15, 1983</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ERIC J. SEIFTER</b>				22e. ADDRESS <b>NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MD. 20205</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/16/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King David Memorial Garden Cem., Falls Church, Va.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons Inc.</b> <b>5130 Wisc. Ave., N.W. Wash., D.C.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 21 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conish</b>	

BP

STATE OF TEXAS



FILE

XX

Wm. J. ...  
Joseph ...  
...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30753

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST WILLARD CHARLES PETERSON		2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 20 1983		2b. HOUR 8:11 a M	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR JUNE 15 1911		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IOWA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BARBER		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE NORTH CAROLINA		13b. COUNTY RUTHERFORD		13c. CITY OR TOWN BOSTIC		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RT #2 BOX 276 99999	
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD GORDON PETERSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAE DANNER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) UNK		331-03-7345		17. INFORMANT ADDRESS PATRICIA I. PETERSON, RT #2, BOX 276, BOSTIC, NC 28018			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a). SMALL CELL CA OF LUNG DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 13, 83, to NOVEMBER 20, 19 83, that (I) (we) lost saw the deceased alive on NOVEMBER 20, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Michael D. Canty		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 21 NOV 83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL D. CANTY, LT, MC, USN		22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov 23, 1983		23c. NAME OF CEMETERY OR CREMATORY Woodland Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Astoria Illinois			
24. FUNERAL DIRECTOR NAME Ives-Pearson F. H. Falls Church, Va. 22046		ADDRESS		25a. DATE REC'D. BY REGISTRAR NOV 25 1983		25b. REGISTRAR'S SIGNATURE R. J. Canty			

MEDICAL CERTIFICATION

*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page.]*

WPA 2000 2000

*[Vertical text and markings on the right margin, including a large handwritten 'C' and other illegible characters.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30754

1. FOR  
STATE  
REGISTRAR

REG. NO.

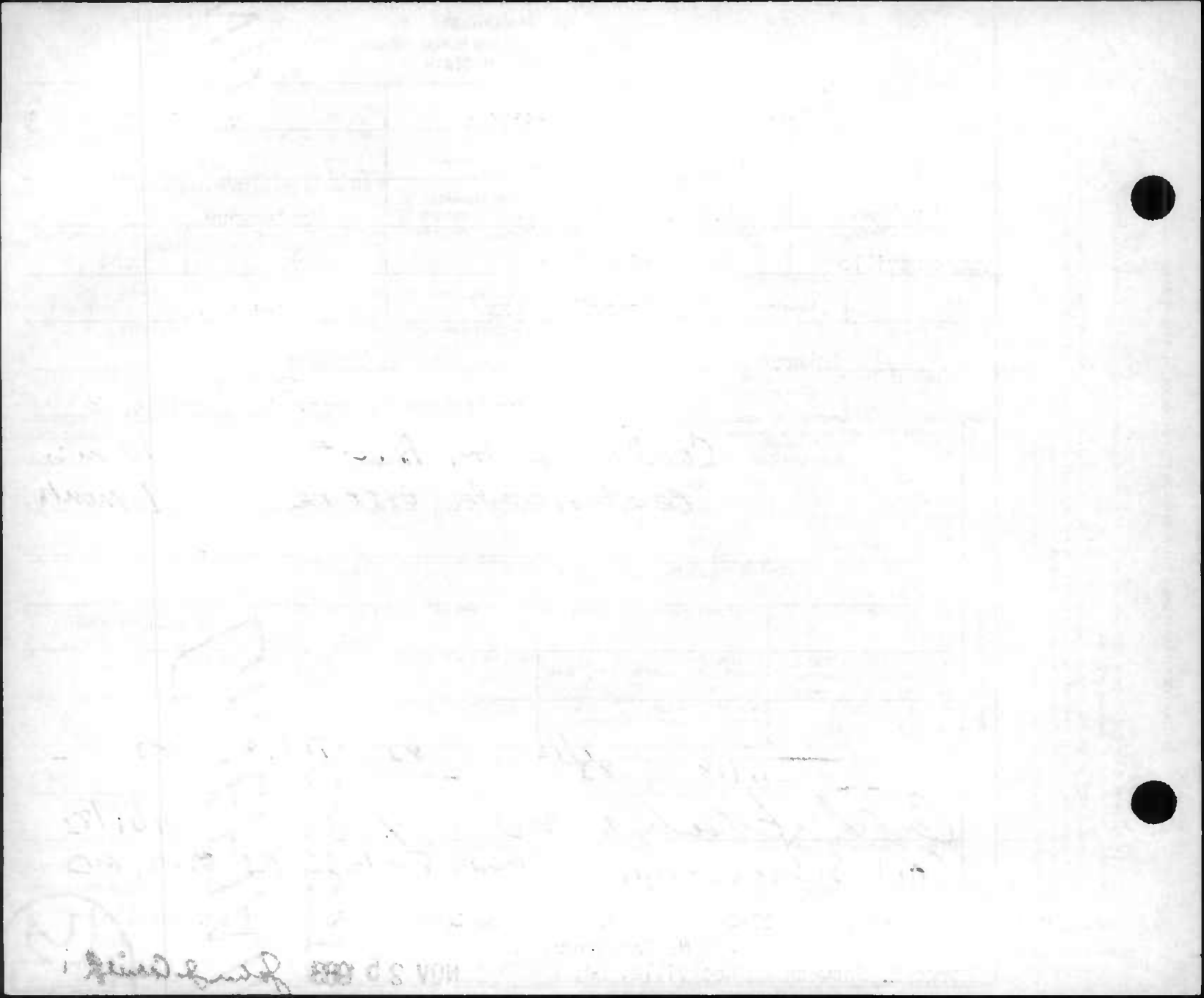
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Frank Phillips</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Nov 21, 83</b>		2b. HOUR <b>8:20 AM</b>
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>May 13, 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.		
10. CITY OR TOWN OF DEATH <b>Laytonsville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>7420 Brink Road</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Cook</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
13a. STATE <b>Md</b>	13b. COUNTY <b>Montg.</b>	13c. CITY OR TOWN <b>Laytonsville</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>7420 Brink Rd.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>6700 Sundown Rd, Mrs Barbara M. Dorsey Laytonsville, Md</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio respiratory Arrest</b> <b>4379</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebrovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b> <b>1 month.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from <b>11/12</b> , 19 <b>83</b> , to <b>11/18</b> , 19 <b>83</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>11/18</b> , 19 <b>83</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above; (I) <input type="checkbox"/> (did not) view the body after death.					
22b. SIGNATURE <b>Carl Schoenberger</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/21/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Carl Schoenberger</b>		22e. ADDRESS <b>16220 Frederick Rd Gaith, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>11-26-83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Marks Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Boyd's, Montg. Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>George R. Snowden</b>		24b. ADDRESS <b>246 N. Washington St. Rockville, Md. 20850</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 25 1983</b>	25b. REGISTRAR'S SIGNATURE <b>Jan J. Carick</b>

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND,  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30755

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Sarah</i> <i>Mason</i> <i>Pineles</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>11</i> <i>26</i> <i>83</i>		2b. HOUR <i>8:58</i> <i>A</i> <i>M</i>
3. SEX <i>Female</i>	4. RACE <i>Caucasian</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>5</i> <i>23</i> <i>23</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>90</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Massachusetts</i>	7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Suburban Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Rockville</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>William</i> <i>Mason</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Agnes</i> <i>Lewis</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>011 05 1151</i>		17. INFORMANT <i>Son</i> ADDRESS <i>Bernard M. Pineles Same as item 13</i>	

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Brain Stem Compression</i> <i>4310</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Intercerebral Hemorrhage</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hypertension</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12 hours</i> <i>36 hours</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>0</i>					
19a. DATE OF OPERATION <i>11/25/83</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Intercerebral Hematoma</i>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M.</i> <i>19</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>11/25</i> 19 <i>83</i> to <i>11/26</i> 19 <i>83</i> that (I) <i>we</i> last saw the deceased alive on <i>11/25</i> 19 <i>83</i> and that in (my) <del>low</del> opinion death occurred on the date and hour and from the causes stated above, (I <del>we</del> <i>we</i> ) (did not) view the body after death.					
22b. SIGNATURE <i>John Thomas Lord</i>		DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>11/26/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John Thomas Lord</i>		22e. ADDRESS <i>7910 Woodmont Ave Bethesda, Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>Nov. 30, 1983</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Waterside Cemetery</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Marblehead, Massachusetts</i>		
24. FUNERAL DIRECTOR NAME <i>ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND</i>		25a. DATE REC'D. BY REGISTRAR <i>NOV 28 1983</i>	25b. REGISTRAR'S SIGNATURE <i>John J. Linnick</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director's office. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director's office. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, there may be injury, or other traumatic event, the medical examiner must be notified at once.

2020 101114

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30756

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>HELEN L. PINKUS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Nov 16, 1983</b>			2b. HOUR <b>6:20 A.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 4 - 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>			
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Memorial Hosp -</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Emp - Dept. Store</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>20912</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Takoma Park</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1326 - Berkeley Ave Tak. Park.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John M. Fitch</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Louise S. Rounney</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		17. SOCIAL SECURITY NO. <b>578-10-3664</b>		17. INFORMANT <b>Audrey Harney (sister) 13e</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:2050 IMMEDIATE CAUSE (a) **Acute myeloid Leukemia**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

30 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

**RUE Pneumonia**

19a. DATE OF OPERATION <b>10-21-1983</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Pneumonia</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>10-21-1983</b> to <b>11-16-1983</b> , that (I) (we) lost saw the deceased alive on <b>11-15-83</b> 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>David Cromwell</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>11-16-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAVID CROMWELL, M.D.</b>				22e. ADDRESS			

MEDICAL CERTIFICATION

1

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 18 - 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland Rd. P. G. Md.</b>	
24. FUNERAL DIRECTOR <b>Takoma Funeral Home, Inc.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 17 1983</b>			
25b. REGISTRAR'S SIGNATURE <b>James J. Goss</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>HAZEL G. PIRIE</b>		2b. DATE KNOWN OF DEATH MONTH DAY YEAR <b>Nov 28 1983</b>		2c. HOUR MIN <b>6:00</b>	
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 13 1933</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>50 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hosp</b>		12a. USUAL OCCUPATION (TYPE OF WORK) <b>Homemaker</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Silver Spring</b>	
14. FATHER'S NAME FIRST <b>(unknown)</b> MIDDLE LAST <b>Cowles</b>		15. MOTHER'S MAIDEN NAME FIRST <b>(unknown)</b> MIDDLE LAST <b>Mead</b>		16. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>13608 Loyola St. Silver Spring, Md.</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>492-34-9266</b>		17. INFORMANT (daughter) <b>Donna P. Shirata</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4411 Ruptured Thoracic Aortic Aneurysm</b> IMMEDIATE CAUSE (a) <b>DUE TO, OR AS A CONSEQUENCE OF</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>DUE TO, OR AS A CONSEQUENCE OF</b> (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <b>None</b>					
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>John S. Rogers</b>		TITLE (SPECIFY) <b>M.D.</b>		DATE SIGNED <b>Nov 28 1983</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>		ADDRESS <b>1919 Seminary Rd., Silver Spring, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec. 2, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Linn Cemetery</b>	
24. FUNERAL DIRECTOR NAME <b>Capitol Funeral Service, Falls Church, VA.</b>		ADDRESS		25a. DATE REC'D. BY REGISTRAR <b>DEC 5 1983</b>	
				25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>	
23d. LOCATION CITY OR TOWN <b>Wentzville, Missouri</b>		COUNTY <b>Missouri</b>		STATE <b>Missouri</b>	



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 22 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. BELT ON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
John						Pitts		Nov 3, 1983		Nov 3, 1983		Nov 3, 1983		Nov 3, 1983		Nov 3, 1983		6 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
M		B/K		3/8/08		75 YRS		MONTHS		DAYS		NOV 3, 1983		NOV 3, 1983		NOV 3, 1983		6 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH		MONTGOMERY		MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		TAK PARK		WASH. A. DUVANT HOSP		Retired		None					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		DC.		Washington		1314 Tenbury		Pitts		Nov 3, 1983	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		John		Rosa		Yes		Third Street, 1129	
Pitts		Jackson		Yes		577 18 5736		Joyce Rollerson, Daughter		1129									
18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		4291		Acute Myocardial Infarction		X		Yrs					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		Chronic Myocardial Infarction		DUE TO, OR AS A CONSEQUENCE OF													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		None																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES		NO		None									
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		21g. CITY OR TOWN		21h. COUNTY		21i. STATE			
WHILE AT WORK		P.M.		ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2		WHILE AT WORK		STREET, FACTORY, FARM, ETC.)		STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held an autopsy		Inspection		Inquiry		and in my opinion death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner			
22a. I certify that I took charge of the remains described above, held an autopsy		Inspection		Inquiry		and in my opinion death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner			
22a. I certify that I took charge of the remains described above, held an autopsy		Inspection		Inquiry		and in my opinion death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner			
22a. I certify that I took charge of the remains described above, held an autopsy		Inspection		Inquiry		and in my opinion death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner			
22a. I certify that I took charge of the remains described above, held an autopsy		Inspection		Inquiry		and in my opinion death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner			
22a. I certify that I took charge of the remains described above, held an autopsy		Inspection		Inquiry		and in my opinion death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner			
22a. I certify that I took charge of the remains described above, held an autopsy		Inspection		Inquiry		and in my opinion death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner			
22a. I certify that I took charge of the remains described above, held an autopsy		Inspection		Inquiry		and in my opinion death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner			
22a. I certify that I took charge of the remains described above, held an autopsy		Inspection		Inquiry		and in my opinion death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner			
22a. I certify that I took charge of the remains described above, held an autopsy		Inspection		Inquiry		and in my opinion death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner			
22a. I certify that I took charge of the remains described above, held an autopsy		Inspection		Inquiry		and in my opinion death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner			
22a. I certify that I took charge of the remains described above, held an autopsy		Inspection		Inquiry		and in my opinion death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner			
22a. I certify that I took charge of the remains described above, held an autopsy		Inspection		Inquiry		and in my opinion death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner			
22a. I certify that I took charge of the remains described above, held an autopsy		Inspection		Inquiry		and in my opinion death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner			
22a. I certify that I took charge of the remains described above, held an autopsy		Inspection		Inquiry		and in my opinion death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner			
22a. I certify that I took charge of the remains described above, held an autopsy		Inspection		Inquiry		and in my opinion death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner			
22a. I certify that I took charge of the remains described above, held an autopsy		Inspection		Inquiry		and in my opinion death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner			

WILDER

WILDER



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

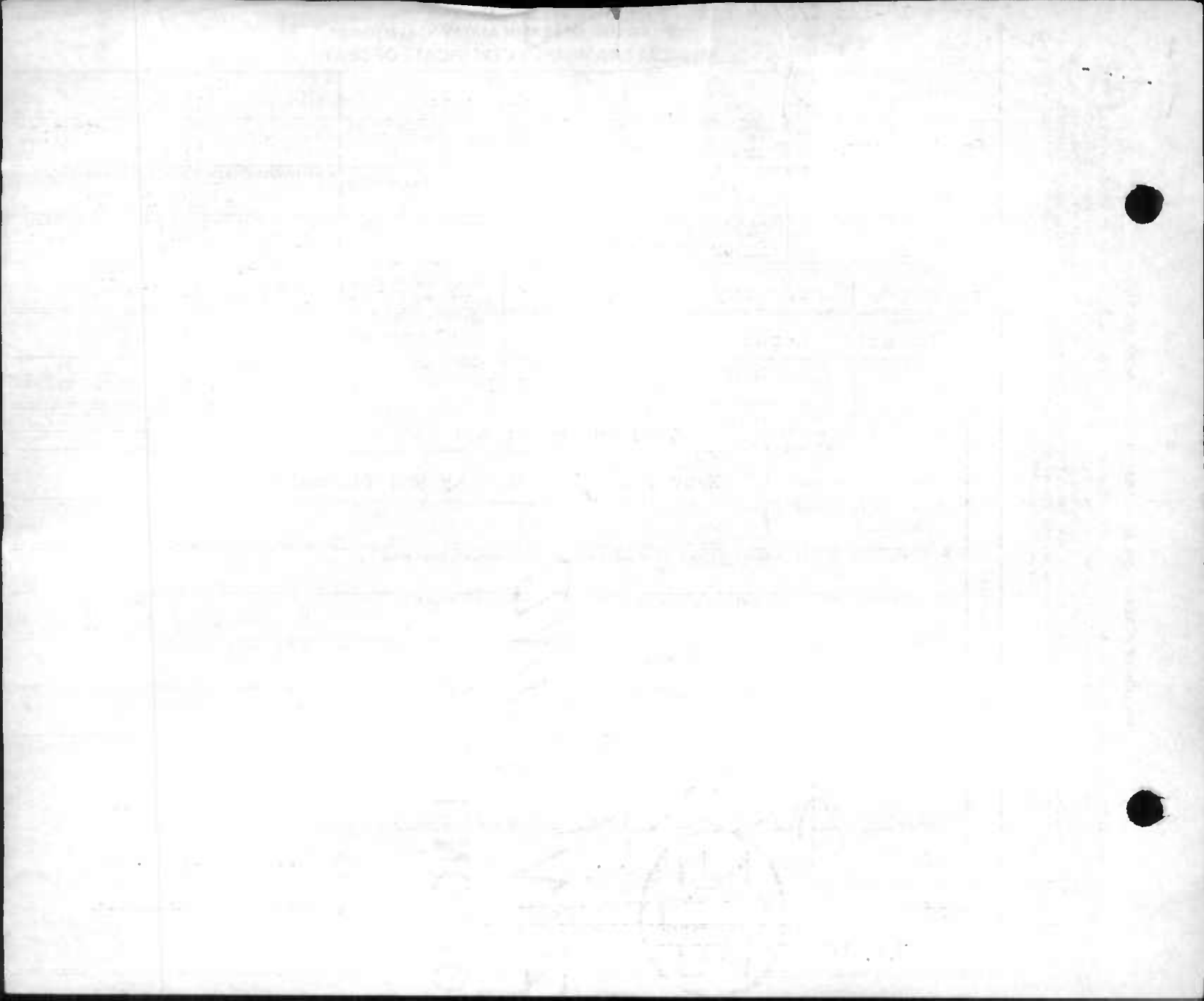
Items 18-22a 2/6/84 mtd

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Pearl A. Pizzamiglio			2a. DATE KNOWN OF DEATH X MONTH DAY YEAR 11/20/83			2b. HOUR M 1:28 A M		
3. SEX female	4. RACE Cauca	5. DATE OF BIRTH MONTH DAY YEAR June 18, 1923	6. AGE (IN YEARS) LAST BIRTHDAY 60 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11/20/83		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED X X NEVER MARRIED WIDOWED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR FACILITY, GIVE WORKING LIFE) Auditor Chevy Chase InnTown		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES X NO		
13e. STREET ADDRESS 6800 Wisconsin Avenue		13f. CITY OR TOWN Bethesda		13g. STATE Maryland		13h. ZIP CODE 20815		
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Leroy Ennis				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Cease				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 348 12 2947		17. INFORMANT Husband Joseph Pizzamiglio Same as item 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4293 } DUE TO, OR AS A CONSEQUENCE OF Myocardial hypertrophy and fibrosis (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES X NO	
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy X, Inspection, Inquiry, and in my opinion death resulted from: Natural causes X, Accident, Suicide, Homicide, Undetermined manner.								
ACTUAL SIGNATURE Ann M. Dixon, M.D.		TITLE (SPECIFY) Assistant			MEDICAL EXAMINER		DATE SIGNED 11/21/83	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn St., Balto., Md. 21201						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov 24 1983		23c. NAME OF CEMETERY OR CREMATORY UP Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Buffalo Wisconsin		
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND				25a. DATE REC'D. BY REGISTRAR NOV 23 1983		25b. REGISTRAR'S SIGNATURE		

BP 370



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with care after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30760

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Paul Johnnie Plowden 111				2a. DATE OF DEATH MONTH DAY YEAR November 25, 1983		2b. HOUR 5:10 A.M.	
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR April 1, 1958		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 25	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH Clinical Center, Bethesda, Md.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE So. Carolina		13b. COUNTY Denmark		13c. CITY OR TOWN Denmark		13d. STREET ADDRESS 537 Church St. 29402	
14. FATHER'S NAME FIRST MIDDLE LAST Paul J. Plowden, Jr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary M. McCain			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 248-21-1986		17. INFORMANT ADDRESS Mrs. Mary M. Brown (mother) same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 2849 IMMEDIATE CAUSE (a) Bilateral hemorrhagic pneumonitis DUE TO, OR AS A CONSEQUENCE OF (b) Aplastic anemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Pan-sinusitis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 16, 1983, to November 25, 1983, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on November 25, 1983, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <del>We</del> (we) did not view the body after death.							
22b. SIGNATURE Ellis Unger MD				DEGREE		22c. DATE SIGNED 11/26/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ELLIS UNGER, M.D.				22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, Md. 20205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov 20, 1983		23c. NAME OF CEMETERY OR CREMATORY Bamberg Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Bamberg, S.C.	
24. FUNERAL DIRECTOR NAME Stewart Funeral Home				24b. ADDRESS 4001 Benning Road, NE.		24c. DATE REC'D. BY REGISTRAR DEC 01 1983	
24d. REGISTRAR'S SIGNATURE John J. Conner							

111

2.5.2

Confidential

Wm. M. Macdonald

Paul J. Brown, Jr.

no

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20

20

20

Chief

Wm. M. Macdonald, Jr.

Stewart, John. Home 1011 10th St. N.W.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH30761  
REG. NO.1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Heinz Poetzschke</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-21-83</b>		2b. HOUR <b>11<sup>21</sup> A.M.</b>		
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 16</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Germany</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Geodesist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Gov't</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Olney</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Max Poetzschke</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Harzbecker</b>		13e. STREET ADDRESS <b>17512 Queen Elizabeth Drive</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>219-38-5331</b>		17. INFORMANT ADDRESS <b>Mrs. Edith Poetzschke (Same as #13.)</b>			

18. CAUSE OF DEATH (Enter only one cause possible for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>0389 Sepsis Secondary to Decubitus</b> IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Sepsis - pseudomonas mallei</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>10/4</b> 19 <b>83</b> , to <b>11/21</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>11/21</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Myron L. Lenkin</b>		DEGREE		22c. DATE SIGNED <b>11/21/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MYRON L. LENKIN</b>		22e. ADDRESS <b>2309 SHOREFIELD RD WHEATON, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>11/21/83</b>		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>		ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 23 1983</b>	
25b. REGISTRAR'S SIGNATURE <b>John J. Grieb</b>					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				30 / 62 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Hilda R Postal</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11 - 19 - 83</b>				2b. HOUR <b>2:20 A.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 15, 1991</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Poland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10. CITY OR TOWN OF DEATH <b>SIL SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Merchant</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Shoes</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>MD</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>SIL SPRING</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>8107 EASTERN AVE 20912</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>David Michael</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE (LAST) <b>FReda Shemberg</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>218-52-2442</b>		17. INFORMANT ADDRESS <b>1131 Univ. Blvd., West Silver Spring, Md. 20902</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4409 a20 TENIA arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>5:45 PM 19 83</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>NOV 18 1983</b> to <b>NOV 19 1983</b> , that (I) (we) last saw the deceased alive on <b>NOV 18 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <b>Robert Kramer, M.D.</b>				DEGREE <b>MD</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/19/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS <b>10313 Georgia Ave S.S. Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>11/20/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>National Capitol Hebrew</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>			
24. FUNERAL DIRECTOR <b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</b> <b>232 CARROLL STREET, N. W., WASHINGTON, D. C.</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conish</b>			

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DHMH - 16 50M 1/76  
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										30763	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST Lucy	MIDDLE C.	LAST Powell	2a. DATE OF DEATH MONTH DAY YEAR November 30, 1983			2b. HOUR 12:45 <sup>M</sup>			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Dec. 17, 1887		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Retirement & Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS (20815) 8612 Jones Bridge Road			
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Clark		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Hood		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No							
16b. SOCIAL SECURITY NO. 577-84-3980		17. INFORMANT ADDRESS Virginia P. Butterfield Bethesda, MD									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>4275</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ADVANCED AGE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min.		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>83</u> , 19 <u>70</u> , to <u>11/30</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive <u>11/30</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <u>Ricardo H. Powell MD</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 11/30/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ricardo H. Powell MD				22e. ADDRESS 1400 Connecticut Ave Kensington MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 2, 1983		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia					
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland				25a. DATE REC'D. BY REGISTRAR DEC 5 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Smith</u>					

STATE OF NEW YORK  
IN SENATE  
JANUARY 11, 1911.

REPORT OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE  
JANUARY 11, 1911.

ALBANY: J. B. LIPPINCOTT & COMPANY, PRINTERS.  
1911.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30764

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John NMN Prem			2a. DATE OF DEATH MONTH DAY YEAR Nov. 16, 1983		2b. HOUR 8:14 P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 18, 1926		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS. MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NO IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Prem			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Pelzar		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. WW II 197-18-4769		17. INFORMANT ADDRESS Olga S. Prem same as 13c	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>CORONARY Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>N/A</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 50 yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>None</u>						
19a. DATE OF OPERATION <u>N/A</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>N/A</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>N/A</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u>N/A</u>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> <u>N/A</u>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PUBLIC) <u>N/A</u>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>N/A</u>		
22a. I certify that (I) (this hospital) attended the deceased from <u>June 15, 1970</u> to <u>16 Nov 83</u> , that (I) (we) last saw the deceased alive on <u>16 Nov 83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Stanley Bialek</u>				DEGREE <u>MD</u>		22c. DATE SIGNED 17 Nov 83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stanley Bialek				22e. ADDRESS 4550 Montgomery Ave. Bethesda, Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/19/83		23c. NAME OF CEMETERY OR CREMATORY George Washington Memorial Park, Plymouth Meeting, Pa.		23d. LOCATION Rockville, Md.
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland 20852				25a. DATE REC'D. BY REGISTRAR NOV 21 1983		25b. REGISTRAR'S SIGNATURE <u>John S. Conner</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP

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BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, indicate any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 30765	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) Robert J Preston						2a. DATE OF DEATH MONTH DAY YEAR 11 8 83		2b. HOUR 3:50P M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 4 18 17		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Lieut. Col.		12b. KIND OF BUSINESS OR INDUSTRY U.S. Air Force			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Montgomery Rockville				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4605 Wilwyn Way		Zip: 20852			
14. FATHER'S NAME FIRST MIDDLE LAST Glenn H. Preston				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not Available							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korea		17. INFORMANT ADDRESS Jacquelyn H. Preston, Wife, Same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia (ventricular fibrillation)</u> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic cardiovascular disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hypercholesterolemia</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>74</u> to <u>11/8</u> , 19 <u>83</u> , that (X) (we) last saw the deceased alive on <u>11/8</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>H. Robert Birschbach, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>11/8/83</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Robert Birschbach, M.D.				22e. ADDRESS 6320 Democracy Blvd. Bethesda, Maryland 20817							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE November 14, 1983		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia					
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Rockville, Maryland				25a. DATE REC'D. BY REGISTRAR NOV 14 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>					

STATE OF NEW YORK

IN SENATE  
January 15, 1903

REPORT OF THE  
COMMISSIONER OF THE LAND OFFICE

FOR THE YEAR 1902

ALBANY:

WILLIAM H. BROWN, PRINTER

1903

Price, 50 CENTS

By Order of the Senate,

JOHN W. BROWN, CLERK

ALBANY:

WILLIAM H. BROWN, PRINTER

1903

Price, 50 CENTS

By Order of the Senate,

JOHN W. BROWN, CLERK

ALBANY:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove co-bonopoppers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30766

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Edith Price</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>Nov 28 '83</i>		2b. HOUR <i>1:40 PM</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>October 2, 1894</i>	
6. AGE (IN YEARS LAST BIRTHDAY) <i>89</i> YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington, D.C.</i>		8. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.		10. CITY OR TOWN OF DEATH <i>Silver Spring, Md</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>University Nursing Home</i>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		13a. STREET ADDRESS <i>1220 Blair Mill Road</i>	
13b. CITY OR TOWN <i>Silver Spring</i>		13c. COUNTY <i>Montgomery</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Morris Siegel</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Rose Stepher</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>	
16b. SOCIAL SECURITY NO. <i>578-62-1277</i>		17. INFORMANT <i>Jack Price</i>		ADDRESS <i>7420 Westlake Terrace, #204 Bethesda, Maryland</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest, Respiratory Arrest</i> 4749 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Artery Disease &amp; Emphysema</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <i>8/10/1982</i> to <i>11/28/1983</i> , that (I) (we) lost saw the deceased alive on <i>11/11/1983</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Tony P. Kannarkat</i>		DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>11/28/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>TONY KANNARKAT, M. D.</i>		22e. ADDRESS <i>8201 16TH STREET, SILVER SPRING, MD. 20910</i>		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>11/29/1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>District of Columbia Lodge Cemetery</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Washington, D. C.</i>		24. FUNERAL DIRECTOR NAME ADDRESS <i>Donald M. Stein Hebrew Memorial F.H.</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 01 1983</i>	
25b. REGISTRAR'S SIGNATURE <i>John J. Gwinn</i>		25c. REGISTRAR'S NAME <i>John J. Gwinn</i>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, when any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Norman PRICE				2a. DATE OF DEATH MONTH DAY YEAR 11-27-83			2b. HOUR 9 <sup>28</sup> A.M.		
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 29 16		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY, MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman			12b. KIND OF BUSINESS OR INDUSTRY Impact Extrusions				
13a. STATE New York		13b. COUNTY Nassau		13c. CITY OR TOWN Massapequa		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 22 Lourae Drive (11762)			
14. FATHER'S NAME FIRST MIDDLE LAST Louis Price		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Levinson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes WWII							
16b. SOCIAL SECURITY NO. 210-01-2190		17. INFORMANT Mary Price; 22 Lourea Drive; Massapequa, N.Y.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Renal Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) Cardiac Disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 11/27 19 83, to 11/27 19 83, that (I) saw the deceased alive on 11/27 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.											
22b. SIGNATURE Carol Bender				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 11/27/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Carol Bender				22e. ADDRESS 4400 Stamp Rd., Temple Hills, MD 20748							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-29-83		23c. NAME OF CEMETERY OR CREMATORY Calverton National Cem.; Long Island, New York			23d. LOCATION CITY OR TOWN COUNTY STATE				
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS 170 Rockville Pike; Rockville, Maryland 20852				25a. DATE REC'D. BY REGISTRAR NOV 30 1983		25b. REGISTRAR'S SIGNATURE John J. Connel					

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Charles Smith

John Smith

John Smith

John Smith

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30768

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Thomas P. Priolo</b>			2a. DATE OF DEATH MONTH <b>11</b> - DAY <b>13</b> - YEAR <b>83</b>		2b. HOUR <b>8:42 P.M.</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>11</b> - DAY <b>8</b> - YEAR <b>15</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery Cty</b> MD.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital of Silver Sp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Civil Engr. U.S. Gov't</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		
13c. CITY OR TOWN <b>Chevy Chase</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS <b>4291 Chevy Chase Blvd, 20815</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Maria</b> MIDDLE <b></b> LAST <b>Rizzo</b>		
14. FATHER'S NAME FIRST <b>Lugi</b> MIDDLE <b></b> LAST <b>Priolo</b>			17. INFORMANT ADDRESS <b>Edna A. Priolo same as 13e</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>207-01-1839</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4100</b> IMMEDIATE CAUSE (a) <b>cardiomyopathy and myocardial infarction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>18 hrs</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>arteriosclerotic cv disease</b>		<b>5 yrs</b>
DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

**Scleroderma**

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>JUNE</b> , 19 <b>76</b> , to <b>11-13</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>11-13</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Bernard H. Ostrow</b>		DEGREE <b>MD</b>	22c. DATE SIGNED <b>11-13-83</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Bernard H. Ostrow</b>		22e. ADDRESS <b>5225 Pooks Hill Rd. Bethesda, Md. 20014</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>11/16/83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>	23d. LOCATION CITY OR TOWN <b>Silver Spring</b> COUNTY <b>Maryland</b>
24. FUNERAL DIRECTOR NAME <b>Tyson Wheeler Funeral Home, Inc.</b> ADDRESS <b>1331 Rockville Pike Rockville, Md. 20852</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 17 1983</b>	25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Continued on next page

1. The first of these is the fact that the number of cases of disease has increased in the last few years. This is due to the fact that the population of the country has increased, and the number of cases of disease has increased in proportion to the increase in population.

2. The second of these is the fact that the number of cases of disease has increased in the last few years. This is due to the fact that the population of the country has increased, and the number of cases of disease has increased in proportion to the increase in population.

3. The third of these is the fact that the number of cases of disease has increased in the last few years. This is due to the fact that the population of the country has increased, and the number of cases of disease has increased in proportion to the increase in population.

4. The fourth of these is the fact that the number of cases of disease has increased in the last few years. This is due to the fact that the population of the country has increased, and the number of cases of disease has increased in proportion to the increase in population.

5. The fifth of these is the fact that the number of cases of disease has increased in the last few years. This is due to the fact that the population of the country has increased, and the number of cases of disease has increased in proportion to the increase in population.

6. The sixth of these is the fact that the number of cases of disease has increased in the last few years. This is due to the fact that the population of the country has increased, and the number of cases of disease has increased in proportion to the increase in population.

7. The seventh of these is the fact that the number of cases of disease has increased in the last few years. This is due to the fact that the population of the country has increased, and the number of cases of disease has increased in proportion to the increase in population.

8. The eighth of these is the fact that the number of cases of disease has increased in the last few years. This is due to the fact that the population of the country has increased, and the number of cases of disease has increased in proportion to the increase in population.

9. The ninth of these is the fact that the number of cases of disease has increased in the last few years. This is due to the fact that the population of the country has increased, and the number of cases of disease has increased in proportion to the increase in population.

10. The tenth of these is the fact that the number of cases of disease has increased in the last few years. This is due to the fact that the population of the country has increased, and the number of cases of disease has increased in proportion to the increase in population.

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					30769 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>VIRGINIA MACPHERSON RAMSAY</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 7 1983</b>			2b. HOUR <b>7:29 a</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MARCH 28 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <b>PENNSYLVANIA ADAMS GETTYSBURG</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>P. O. BOX 675</b>		99999
14. FATHER'S NAME FIRST MIDDLE LAST <b>OLIVER GLEN MACPHERSON</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ELSIE FRALEY</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>RICHARD F. RAMSAY, JR., 1595 HERR'S RIDGE ROAD</b>		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA AND SEPSIS</b> 2028 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>LYMPHOMA</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF					GETTYSBURG, PA 17325 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>SEPTEMBER 21 19 83</b> to <b>NOVEMBER 7 19 83</b> , that (I) (we) lost saw the deceased alive on <b>NOVEMBER 7 19 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>James P. Asher</i> MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>8 Nov 83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JEANNE P. ASHER, LT, MC, USNR</b>					22e. ADDRESS <b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Nov. 8, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria, Virginia</b>			
24. FUNERAL DIRECTOR NAME <i>Monahan</i> ADDRESS <b>Monahan Funeral Home Gettysburg, Pennsylvania</b>					25. DATE OF REGISTRATION <b>NOV 16 1983</b>				

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WASHINGTON, D.C.

OFFICE OF THE SECRETARY

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Item #8 1/10/84 mtb #587

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Magdalene Elizabeth RAULIN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 23, 1983</b>		2b. HOUR <b>5:50 PM</b>
3. SEX <b>female</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 15 1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C. USA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>MARYLAND</b>	13b. COUNTY <b>MONTGOMERY</b>	13c. CITY OR TOWN <b>S.S.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>13010 NEW HAMPSHIRE AVE.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Adam Volland</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Augusta R Streb</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>None</b>		16b. SOCIAL SECURITY NO. <b>215 74 0689</b>		17. INFORMANT <b>Same as above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4275 CARDIOPULMONARY ARREST</b> IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>DORGANIC BRAIN SYNDROME (2) RECURRENT SYNCOPE, ETOL. UNKNOWN</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/23, 1983</b> , to <b>11/23, 1983</b> , that (I) (we) last saw the deceased alive on <b>11/23, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Quentin A. Fisher MD</b>		DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/28/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Burtonsville Mont. Md.</b>		23e. DATE REC'D. BY REGISTRAR <b>NOV 28 1983</b>		23f. REGISTRAR'S SIGNATURE <b>John J. Lomick</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Hines/Rinaldi 11800 New Hampshire Ave. S.S. MD.</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be filed with the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30771

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST HENRY Marston RAYMOND, Sr.			MONTH DAY YEAR 11 17 83			HOURS MIN. 12 54 PM		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE	Caucasian	MONTH DAY YEAR 2 12 10		73 YRS.		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Washington, D.C.	U.S.A.			MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
SILVER SPRING	HOLY CROSS HOSP. SILVER SPRING			Guard		Gallery of Art		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS?		13. STREET ADDRESS			
13a. STATE 13b. COUNTY 13c. CITY OR TOWN MARYLAND MONTGOMERY SILVER SPRING			YES <input type="checkbox"/> NO <input type="checkbox"/>		4700 BRISTOL AVENUE 20901			
14. FATHER'S NAME FIRST MIDDLE LAST Alrose Raymond			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Schirmer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.		17. INFORMANT			
Yes WWII			579-38-8441		Ann W. Raymond Wife Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary heart disease								years
DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus; chronic obstructive lung disease								years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 18								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
					April 19 77 to 11-17 19 83			
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 11-17-1983 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								22c. DATE SIGNED 11-17-83
23a. SIGNATURE JASON BELGER, M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
23b. PHYSICIAN'S NAME (TYPE OR PRINT)			22a. ADDRESS					
JASON BELGER, M.D.			830 CAMERON STREET SILVER SPRING, MD. 20910					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial			Nov. 21, 1983		Gate of Heaven		Silver Spring Mont. Md.	
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Francis J. Collins			NOV 25 1983			John J. Grieb		
500 University Blvd., W. Silver Spring, Md.								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use on the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten notes and sketches, including a circular diagram with the number 101 inside, and various lines and scribbles.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30772

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Albert Reinthal</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 10 83</b>			2b. HOUR <b>1:00AM</b>			
3 SEX <b>Male</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 11, 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Auditor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Albert E. Reinthal</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Daisy Heavenrich</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWI</b>		17. INFORMANT <b>Ida Reinthal</b>		ADDRESS <b>3360 Chiswick Ct. Silver Spring, Md. 20906</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4149 Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Pulmonary Edema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Disease</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Duke's</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>11/10</u> , 19 <u>83</u> , to <u>11/10</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>11/10</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>		DEGREE <u>[Signature]</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/10/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Daniel Goldberg</b>				22e. ADDRESS <b>10401 Old Georgetown Rd. Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>11/10/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Georgetown Med. School</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Columbia Mortuary Services, Inc. 225 Missouri Ave. NW Washington, D.C. 20011</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 18 1983</b>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION



Alberts	Male	Canada	Jan. 11, 1903	80	11 30 B	2:00 PM
New York	U.S.A.	X				
Chief	Montgomery General Hospital	Assistant	Resident			
Hayland	Mont.	Silver Spring	X	3300 Chiswick Ct. 20906		
Albert H. Reinthal		Delay	Reverend			
Yes	WI	103-22-0104	Ida Reinthal	Silver Spring, Md. 20906		

*[Faint, illegible handwritten notes and signatures]*



Removal  
225 Missouri Ave. NW Washington, D.C. 20011  
Columbia Northern Services, Inc.  
11/10/1983 Georgetown Med. School Washington, D.C.  
NOV 18 1983  
J. G. G. G.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30773

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Helen D. Remley</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 28, 1983</b>		2b. HOUR A M <b>12:30 A</b>		
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 1, 1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <b>99</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Althea Woodland Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Administrative Asst</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Treasury Dept.</b>	
13a. STATE <b>D.C.</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2115 "E" Street, N.W.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>David L. Day</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Caroline Swisher</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>579-60-5840</b>	
17. INFORMANT <b>Son</b>		18. ADDRESS <b>4404 Oxford Street Garrett Park, Md 20896</b>		19. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Althea Woodland Nursing Home</b>		20. DATE OF DEATH <b>NOVEMBER 28, 1983</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4140</b> IMMEDIATE CAUSE (a) <b>Coronary Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. I certify that (I) (this hospital) attended the deceased from <b>Dec. 3, 1968</b> to <b>Nov. 13, 1983</b> , that (I) (we) last saw the deceased alive on <b>Nov. 13, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <b>[Signature]</b> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED <b>Nov. 28, 1983</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jack Kleh, M.D.</b>		22e. ADDRESS <b>1145 K Street, N. W. Washington, D.C.</b>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>	
23b. DATE <b>Nov. 28, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria Virginia</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Francis J. Collins 500 University Blvd., W. Silver Spring, Md.</b>	
25a. DATE REC'D. BY REGISTRAR <b>DEC 2 1983</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		25c. DATE REC'D. BY REGISTRAR <b>DEC 2 1983</b>		25d. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30774

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>GERALDINE W. RICE</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>NOV. 8, 1983</b>				2b. HOUR <b>3:12 AM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 4 28</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.			
10. CITY OR TOWN OF DEATH <b>SIL Spg, Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>MD.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>8210--16th St. 20910</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William McDowell Williams</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Vera Spears</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>579-32-5469</b>		17. INFORMANT ADDRESS <b>Paul J Rice. Same as item 13</b>					

18. CAUSE OF DEATH PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Respiratory failure</b> <b>4290</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiogenic shock from Coronary artery</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>myocardial infarction, Renal failure, Diabetes</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>10/27/1983</b> to <b>11/7/1983</b> , that (I) (we) last saw the deceased alive on <b>11/7/1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURES <b>Tony P. Kannarkat MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/8/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Tony P. KANNARKAT</b>				22e. ADDRESS <b>8201 16th St S.S. MD 20910</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/10/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons Inc.</b>				25. DATE REC'D. BY REGISTRAR <b>NOV 14 1983</b>			
24. ADDRESS <b>5130 Wisc. Ave., Wash., D.C.</b>				REGISTRAR'S SIGNATURE <b>James J. Galloway</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30775

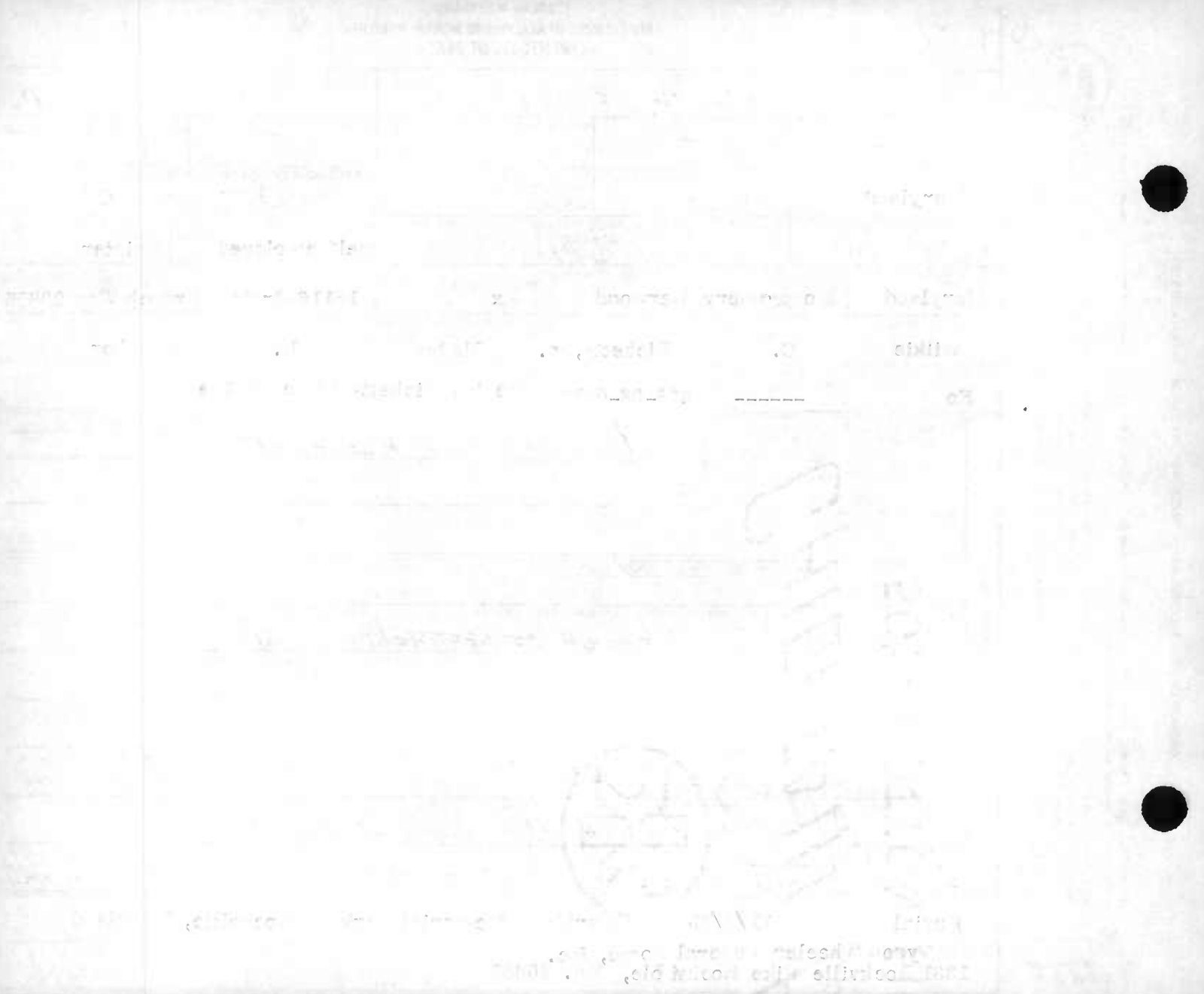
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CLARENCE J. RICKETTS</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>2</b> YEAR <b>83</b>			2b. HOUR <b>11:55 P.M.</b>					
3. SEX <b>MALE</b>		4. RACE <b>CAUS.</b>		5. DATE OF BIRTH MONTH <b>9</b> DAY <b>12</b> YEAR <b>28</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BETH. MD.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUBURBAN HOSP.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>self employed</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Painter</b>		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Derwood</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>16116 Crabbs Branch Way 20855</b>			
14. FATHER'S NAME FIRST <b>Wilkie</b> MIDDLE <b>C.</b> LAST <b>Ricketts, Sr.</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Gladys</b> MIDDLE <b>L.</b> LAST <b>Gamber</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATE) <b>578-38-0710</b>		17. INFORMANT ADDRESS <b>Regina Ricketts same as 13e</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4598 IMMEDIATE CAUSE (a) PULMONARY EMBOLISM</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION <b>10-21-83</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>IS Chemia of Left Foot</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>10-16</b> 19 <b>83</b> , to <b>11-2</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>11-2</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>C. Alberto Nunez, MD</b>		DEGREE <b>MD</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>C. Alberto Nunez</b>		22e. ADDRESS <b>8718 HISCONSIN AVE. BETHESDA</b>									
23a. BURIAL, CREMATION, REMOVAL (TYPE) <b>Burial</b>		23b. DATE <b>11/5/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Memorial Park</b>		23d. LOCATION CITY OR TOWN <b>Rockville, Maryland</b>		STATE			
24. FUNERAL HOME OR OTHER PLACE OF INTERMENT <b>Dyson Wheeler Funeral Home, Inc.</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 7 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>			
1331 Rockville Pike Rockville, Md. 20852											

MEDICAL CERTIFICATION

29

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30776

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Meese Labin Rider</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>November - 6-83</i>			2b. HOUR <i>4:05 AM</i>				
3. SEX <i>Male</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Jan. 14 14</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>69</i>		7. IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>W. Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County</i> MD.				
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Postal Clerk</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>US Postal office</i>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>md</i>			13b. COUNTY <i>Mont.</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>12 Vashi Lane</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Gray Rider</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Elexa Labin</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. (YES OR UNKNOWN) <i>WW II</i>		17. INFORMANT <i>Wife</i>		ADDRESS <i>Dorothy E. Rider Same as item 13</i>				

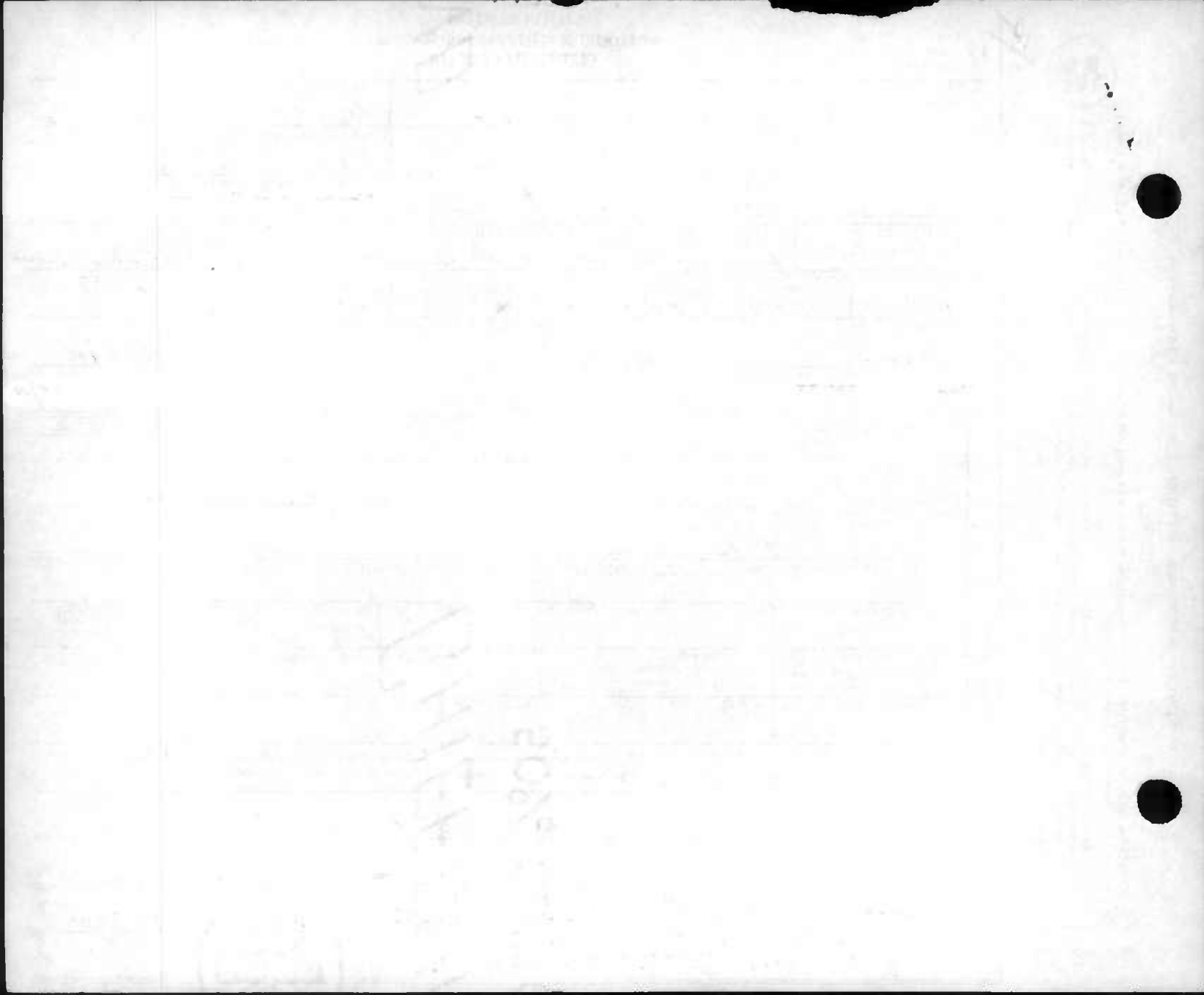
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) <i>Probable septic shock</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i>	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <i>Metastatic Large Cell Lung Carcinoma</i>	
		DUE TO, OR AS A CONSEQUENCE OF (c)	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: *a*

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>10/23</i> 19 <i>83</i> , to <i>11/6</i> 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>11/5</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Adam Black</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>11/6/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Adam Black</i>				22e. ADDRESS <i>10500 Summit Ave, Kensington, MD</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Nov. 9, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Memorial</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Rockville, Maryland</i>	
24. FUNERAL DIRECTOR NAME <i>ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND</i>				25a. DATE REC'D. BY REGISTRAR <i>NOV 7 1983</i>			
				25b. REGISTRAR'S SIGNATURE <i>John J. Smith</i>			

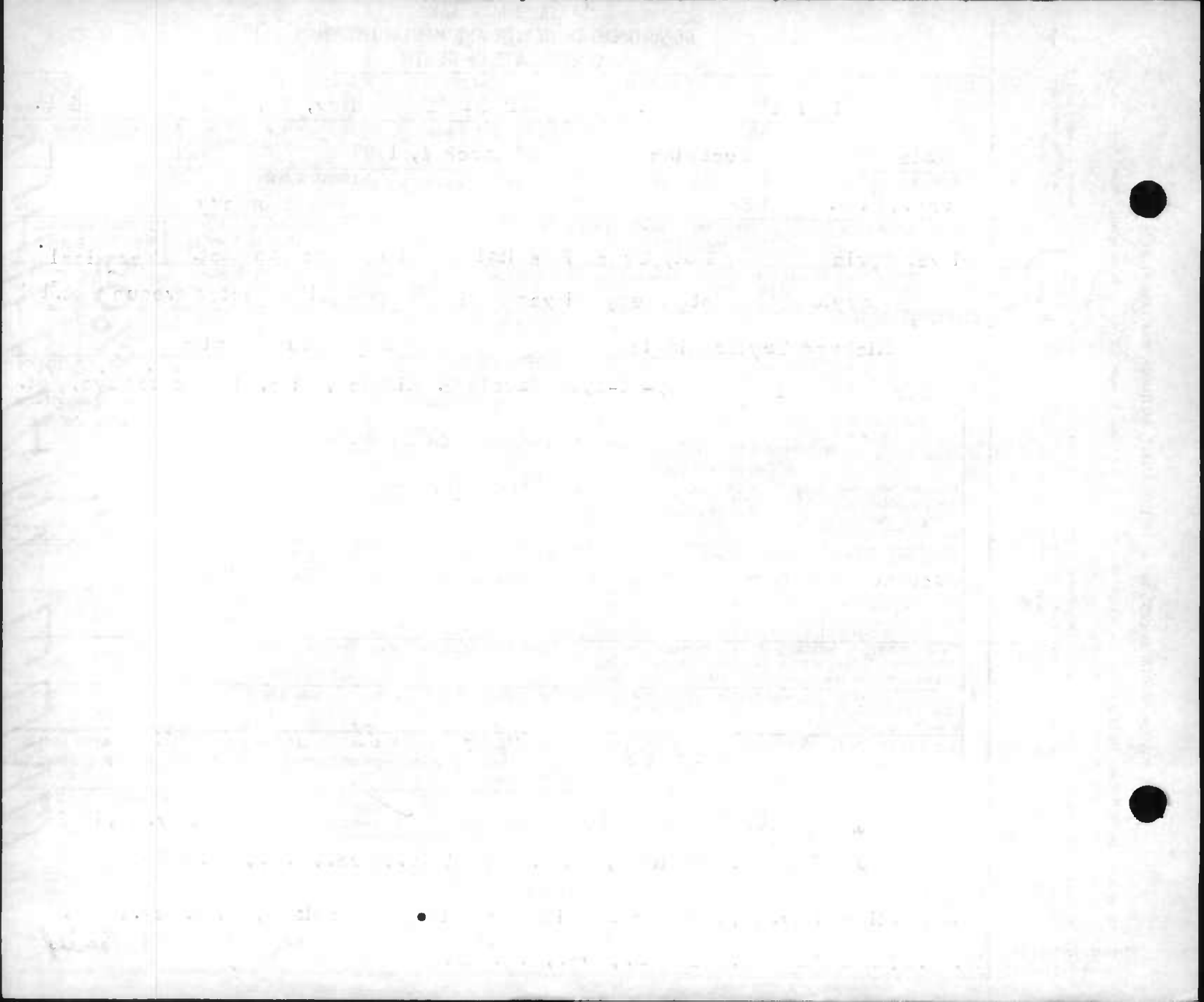


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last HENRY E. RIDGLEY			2a. DATE OF DEATH Nov, 27, 1983 Day Year		2b. HOUR 4 P. M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH March 4, 1897		6. AGE (In years last birthday) 86 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Wash., D. C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Gang Foreman Ret.	12b. KIND OF BUSINESS OR INDUSTRY Wash. Terminal		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2102 Dexter Avenue Apt. 101	
14. FATHER'S NAME First Middle Last Richard Taylor Ridgley	15. MOTHER'S MAIDEN NAME First Middle Last Mary Maud Walls				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16b. SOCIAL SECURITY NO. WW 1 719-01-2914	17. INFORMANT Address S. S. Md. 20902 Sara H G. Ridgley, Wife, 2102 Sexter Ave, Apt. 101			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiovascular collapse -</u> <u>5679</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute peritonitis -</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>severe coronary artery disease - chronic lung disease</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>11/19</u> , 19 <u>83</u> , to <u>11/27</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>11/27/83</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE JO. Joseph M. Solinas		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED Nov. 28, 1983		
22d. PHYSICIAN'S NAME (Type) JOSEPH M. SOLINAS, M.D.		22e. ADDRESS 9801 Ga., Ave., S. S., Md. 20902			
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) Cremation	23b. DATE Nov. 28, 1983	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	23d. LOCATION (City or Town) (County) (State) Suitland, P. G. Cty., Md.		
24. FUNERAL DIRECTOR W. W. CHAMBERS CO. 8655 Ga., Ave., S. S. Md.		ADDRESS 20910	25a. RECD. BY REGISTRAR DATE NOV 30 1983	25b. REGISTRAR'S SIGNATURE John J. Connel	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or boxed, item 11 shows any injury, or other traumatic event, the medical examiner will be notified of this.

BP \_\_\_\_\_

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)

Charles D. Robey

20. DATE OF DEATH MONTH DAY YEAR  
11-26-83

2b. HOUR 5:28 PM

3. SEX

MALE

4. RACE

WHITE

5. DATE OF BIRTH

JULY 16 1902

6. AGE (IN YEARS LAST BIRTHDAY)

81

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

MARYLAND

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Montgomery MD

10. CITY OR TOWN OF DEATH

Bethesda

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Suburban Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

CARPENTER

12b. KIND OF BUSINESS OR INDUSTRY

CONSTRUCTION

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE 13b. COUNTY 13c. CITY OR TOWN

MD PG LAUREL

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

600 CARROLL AVE

14. FATHER'S NAME

NEAMAR

MIDDLE

ROBEY

LAST

ROBEY

15. MOTHER'S MAIDEN NAME

ALICE

MIDDLE

AITCHESON

LAST

AITCHESON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

213-05-8325

17. INFORMANT

25 MYRTLE ROBEY

ADDRESS

SAME

17b. AS ABOVE

AS ABOVE

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) 4100

DUE TO, OR AS A CONSEQUENCE OF

(b) acute myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF

(c) atherosclerotic cardiovascular disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

10 min

5 days

10 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ AT WORK NOT WHILE ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 11/23 1983 to 11/26 1983, that (I) (we) lost saw the deceased alive on 11/26 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Samuel D. Goldberg MD

DEGREE

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

11-27-83

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Samuel D. Goldberg MD

22e. ADDRESS

11125 Rockville Pk., Rockville, Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b. DATE

NOV. 30, 1983

23c. NAME OF CEMETERY OR CREMATORY

FORT LINCOLN

23d. LOCATION

BRENTWOOD

COUNTY

MD

STATE

24. FUNERAL DIRECTOR

DONALDSON FUNERAL HOME

ADDRESS

LAUREL MD

25a. DATE REC'D. BY REGISTRAR

DEC 2 1983

25b. REGISTRAR'S SIGNATURE

John J. Conner



Dec 2 1930



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

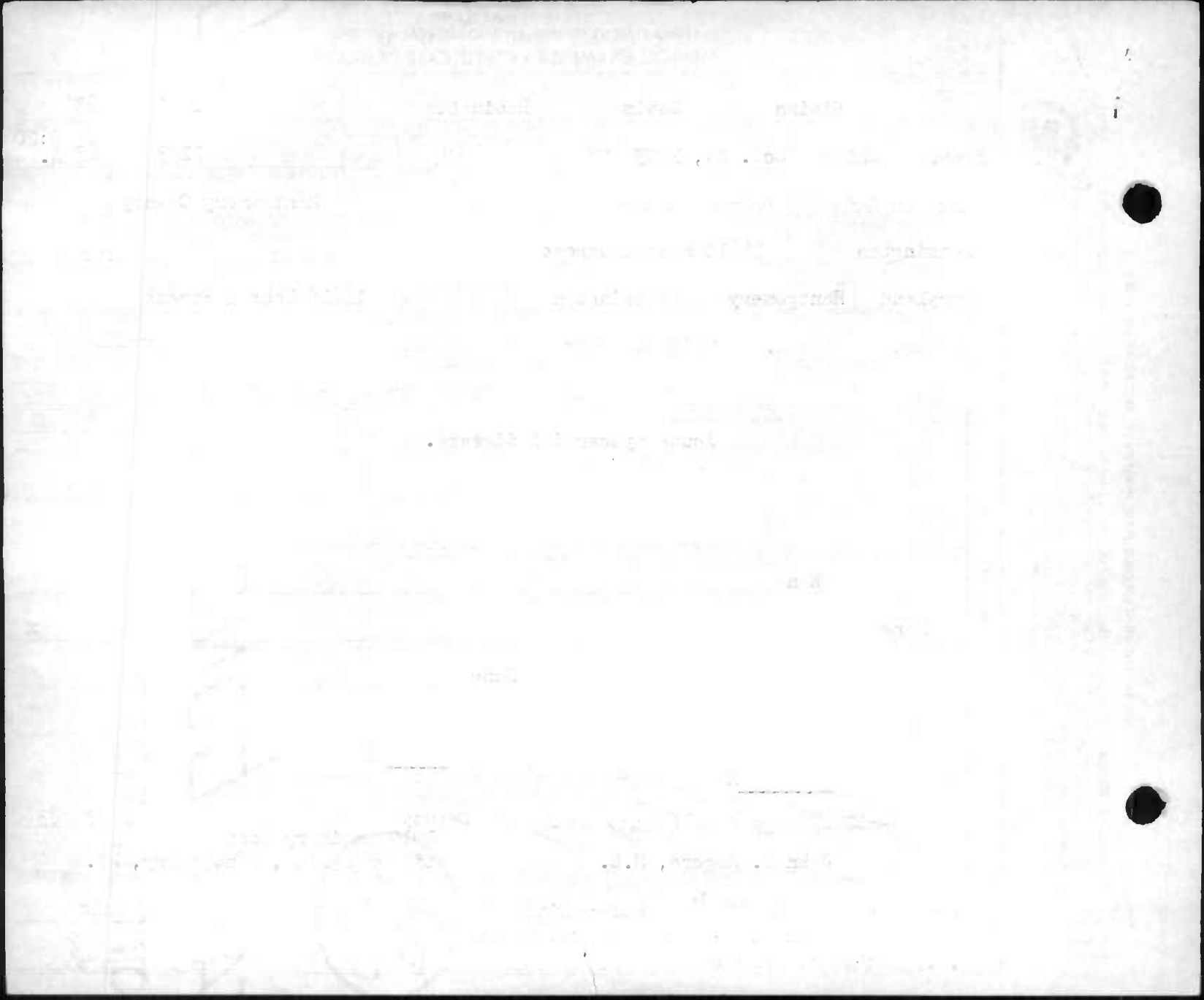
BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE REGISTRAR		FOR		3 0 7 7 9	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE	
Vivian Davis Robinette					
2a. DATE KNOWN OF DEATH	<input checked="" type="checkbox"/> MONTH	DAY	YEAR	2b. HOUR	
11/30	19	83			
2c. DATE PRONOUNCED DEAD	<input type="checkbox"/> MONTH	DAY	YEAR	2d. HOUR	
11/30	19	83			
3. SEX	4. RACE	5. DATE OF BIRTH (MONTH DAY YEAR)	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR (MONTHS DAYS)	8. IF UNDER 24 HRS. (HOURS MIN)
Female	White	Oct. 24, 1905	78 YRS.		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
West Virginia	Kensington	10810 Hobson Street	Teacher	Education	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> )	13e. STREET ADDRESS	
Maryland	Montgomery	Kensington		10810 Hobson Street	
14. FATHER'S NAME (FIRST MIDDLE LAST)	15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)				
Robert S. Eichelberger	Bessie Powell				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS		
No	579-09-0968	Susan Strnad Daughter	Same as 13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease.</u> 4291 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
None					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> )			
None					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY (HOUR A.M. MONTH DAY YEAR P.M. 19)	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		None			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION (STREET CITY OR TOWN COUNTY STATE)			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
John S. Rogers, M.D.		Deputy		11/30/83	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
John S. Rogers, M.D.		1919 Seminary Road		Silver Spring, Montgomery, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (CITY OR TOWN COUNTY STATE)		
Cremation	Dec. 1, 1983	Metropolitan Crematory	Alexandria Virginia		
24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE			
Robert A. Humphrey Funeral Homes, P.A., Bethesda, Maryland	DEC 2 1983	John J. Canine			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

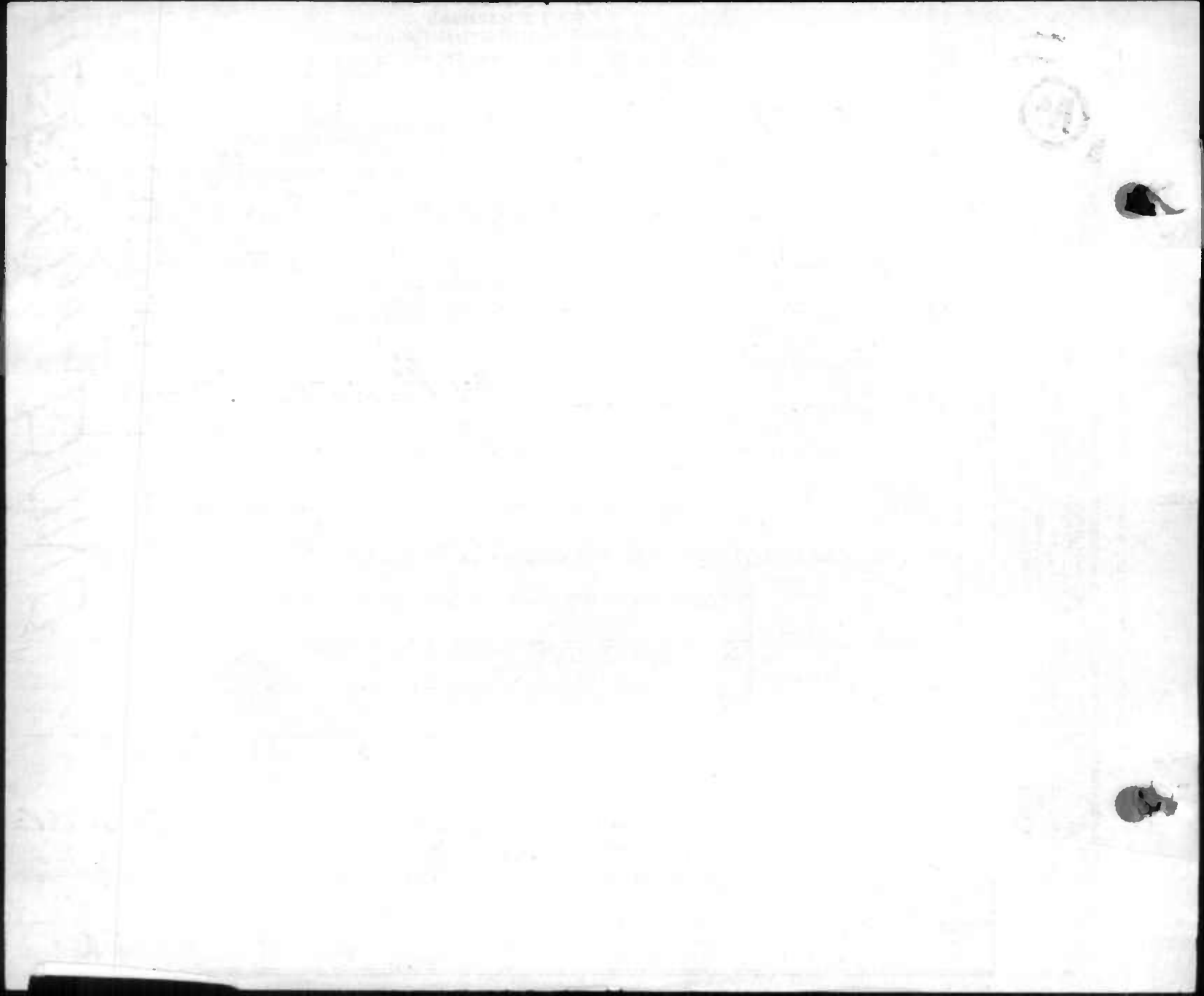
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

30780

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH DAY YEAR		2b. HOUR	
Kathryn Frances Robinson								10-2-83		P		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Female	Cauca	Oct. 7, 1909		74 YRS.						Dec. 26 1983		10:30	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Washington DC		United States				Montgomery County							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Silver Spring		3712 Cameron Street #305		Secretary		Plumbing Co.							
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		Montgomery		Silver Spring		XX NO		8712 Cameron Street 20910					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Charles W. Robinson		Elizabeth Kee											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
NO		225-05-1579		Mr. Philip E. Kee, Cousin,		20855 6913 Muncaster Mill Rd., Derwood, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 4291 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
None													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?									
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
		P.M. 19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED							
John S. Rogers, M.D.		1919 Seminary Rd. Silver Spring MD				Dec 24 1983							
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS											
Burial		3, 1984		Fort Lincoln Cemetery Brentwood, Maryland									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		3, 1984		Fort Lincoln Cemetery Brentwood, Maryland									
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
ROBERT A. PUMPHREY FUNERAL HOMES, P.A. BETHESDA, MARYLAND		JAN 9 1984		John J. Comer									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR				REG. NO. 30781					
1. DECEASED NAME (TYPE OR PRINT) JOHN NORWOOD RODGERS				2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 28 1983				2b. HOUR 9:50 P M	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR SEPTEMBER 28 1908		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY U.S.A.F.	
13a. STATE MARYLAND				13b. COUNTY MONTGOMERY		13c. CITY OR TOWN KENSINGTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM B. RODGERS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLORA R. BARR					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1934-1968		17. INFORMANT ADDRESS GEORGINE R. RODGERS, 3712 CALVEND LANE,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LUNG FAILURE 2000 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) } (c) } DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>OCTOBER 3</u> , 19 <u>83</u> , to <u>NOVEMBER 28</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>NOVEMBER 28</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE 				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 29 NOV 83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. CHERNOW, LCDR, MC, USN				22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/2/83		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, VA			
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash., DC 20016				25a. DATE REC'D. BY REGISTRAR DEC 2 1983					
				25b. REGISTRAR'S SIGNATURE 					

10/10/10 10:10:10



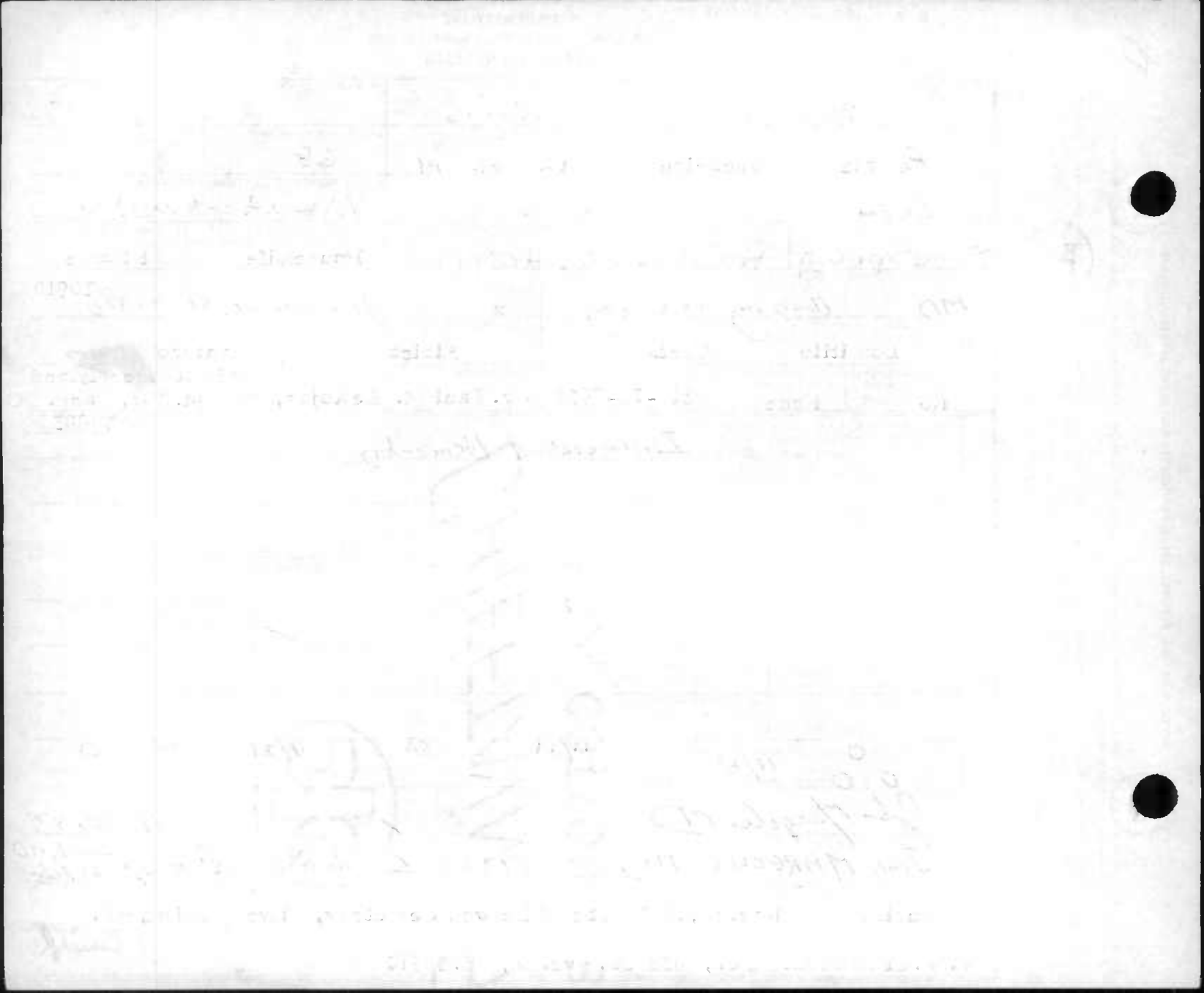
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. Page 4 should be retained by the funeral director. Page 5 should be retained by the funeral director. Page 6 should be retained by the funeral director. Page 7 should be retained by the funeral director. Page 8 should be retained by the funeral director. Page 9 should be retained by the funeral director. Page 10 should be retained by the funeral director. Page 11 should be retained by the funeral director. Page 12 should be retained by the funeral director. Page 13 should be retained by the funeral director. Page 14 should be retained by the funeral director. Page 15 should be retained by the funeral director. Page 16 should be retained by the funeral director. Page 17 should be retained by the funeral director. Page 18 should be retained by the funeral director. Page 19 should be retained by the funeral director. Page 20 should be retained by the funeral director. Page 21 should be retained by the funeral director. Page 22 should be retained by the funeral director. Page 23 should be retained by the funeral director. Page 24 should be retained by the funeral director. Page 25 should be retained by the funeral director. Page 26 should be retained by the funeral director. Page 27 should be retained by the funeral director. Page 28 should be retained by the funeral director. Page 29 should be retained by the funeral director. Page 30 should be retained by the funeral director. Page 31 should be retained by the funeral director. Page 32 should be retained by the funeral director. Page 33 should be retained by the funeral director. Page 34 should be retained by the funeral director. Page 35 should be retained by the funeral director. 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Page 55 should be retained by the funeral director. Page 56 should be retained by the funeral director. Page 57 should be retained by the funeral director. Page 58 should be retained by the funeral director. Page 59 should be retained by the funeral director. Page 60 should be retained by the funeral director. Page 61 should be retained by the funeral director. Page 62 should be retained by the funeral director. Page 63 should be retained by the funeral director. Page 64 should be retained by the funeral director. Page 65 should be retained by the funeral director. Page 66 should be retained by the funeral director. Page 67 should be retained by the funeral director. Page 68 should be retained by the funeral director. Page 69 should be retained by the funeral director. Page 70 should be retained by the funeral director. Page 71 should be retained by the funeral director. Page 72 should be retained by the funeral director. Page 73 should be retained by the funeral director. Page 74 should be retained by the funeral director. Page 75 should be retained by the funeral director. Page 76 should be retained by the funeral director. Page 77 should be retained by the funeral director. Page 78 should be retained by the funeral director. Page 79 should be retained by the funeral director. Page 80 should be retained by the funeral director. Page 81 should be retained by the funeral director. Page 82 should be retained by the funeral director. Page 83 should be retained by the funeral director. Page 84 should be retained by the funeral director. Page 85 should be retained by the funeral director. Page 86 should be retained by the funeral director. Page 87 should be retained by the funeral director. Page 88 should be retained by the funeral director. Page 89 should be retained by the funeral director. Page 90 should be retained by the funeral director. Page 91 should be retained by the funeral director. Page 92 should be retained by the funeral director. Page 93 should be retained by the funeral director. Page 94 should be retained by the funeral director. Page 95 should be retained by the funeral director. Page 96 should be retained by the funeral director. Page 97 should be retained by the funeral director. Page 98 should be retained by the funeral director. Page 99 should be retained by the funeral director. Page 100 should be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

# 8 Film 6586 1215183 PM										STATE OF MARYLAND																			
1. FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE																			
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE OF DEATH MONTH DAY YEAR																			
Nicoleen B. Rojas										11 24 83 5:52 AM																			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS														
Female			Caucasian			12 06 14			68 YRS.			MONTHS DAYS HOURS MIN.																	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH																				
CUBA									Montgomery MD.																				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY																				
Silver Spring			Holy Cross Hospital			Housewife			At Home																				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			20910														
MD			Montgomery			Silver Spring			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1700 Keweenaw St #810																	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS														
Domitilo Costa			Eloisa Montoro			No			218-76-7634			Mr. Paul M. DeRojas, Son			1437 Rhodes Island Apt. 207, Wash. DC														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral Hemorrhage</u>										APPROXIMATE BETWEEN CAUSE AND DEATH <u>20005</u>																			
4310 DUE TO, OR AS A CONSEQUENCE OF (b) _____																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?														
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					YES <input type="checkbox"/> NO <input type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																			
					P.M. 19																								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION CITY OR TOWN COUNTY STATE																			
22a. I certify that (this hospital) attended the deceased from <u>11/19</u> , 19 <u>83</u> , to <u>11/24</u> , 19 <u>83</u> , that (we) last saw the deceased alive on <u>11/23</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did not) view the body after death.																													
22b. SIGNATURE <u>John Margolis MD</u> DEGREE _____										22c. DATE SIGNED <u>11/35/83</u>																			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>John MARGOLIS MD</u>										22e. ADDRESS <u>14333 Laurel Bowie Rd #307 20705</u>																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION CITY OR TOWN COUNTY STATE														
Burial					Nov. 28, 1983					Gate of Heaven Cemetery					Silver Spring, Md.														
24. FUNERAL DIRECTOR NAME <u>W. W. CHAMBERS CO., 8655 Ga. Ave. SS, Md. 20910</u>										25a. DATE RECEIVED BY REGISTRAR <u>NOV 30 1983</u>										25b. REGISTRAR'S SIGNATURE <u>J. Chambers</u>									





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

30783

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTI- MATED		MONTH		DAY		YEAR		2b. HOUR	
Fanny		Rosenthal						11		12		83		10		00		A M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
F	W	4 1 88		95		MONTHS		DAYS		HOURS		MIN.		11		12		83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH											
Austria		U.S.A.		WIDOWED		XX		DIVORCED										MONTGOMERY, MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Damascus		28532 Woodview Dr.		Homemaker		Home													
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		Montgomery		Damascus		YES		NO		28532 Woodview Dr.								20872	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST									
(unknown)		Sternlieb		(unknown)															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
no		103-20-0242 A		Shirley Anderman		28532 Woodview Dr.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF	
4140		Cardiac arrest		Coronary arteriosclerosis															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES		NO		XX									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE									
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input type="checkbox"/>		and in my opinion											
death resulted from:		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED															
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS																	
John Tauber		8218 Wisconsin Ave.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE									
Burial		11-14-1983		Cedar Park Cemetery		Westwood, New Jersey													
24. FUNERAL DIRECTOR NAME		ADDRESS																	
Danzansky-Goldberg Chapels		1170 Rockville Pike																	

NOV 17 1983

John J. Tauber

Printed by J. P. VON

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

30784

1- FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Sol J. ROSENTHAL						2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR Nov 16 1983		2b. HOUR 10:12	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 1, 1903		6. AGE (IN YEARS) LAST BIRTHDAY 80 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Nov. 16, 1983		2d. HOUR 10:12
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital, Silver Spring				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Manager		12b. KIND OF BUSINESS OR INDUSTRY Floor Machines	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSURE (CITY LIMITS?) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11200 Lockwood Drive, #807	
14. FATHER'S NAME FIRST MIDDLE LAST Phillip Rosenthal				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophie (unknown)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 090-09-1684		17. INFORMANT Funeral Home, New York, N.Y. 10003 Mr. Donza; Funeral Director; Brettschneider			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4291 IMMEDIATE CAUSE (a) Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None									
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE John S. Rogers M.D.		TITLE (SPECIFY) MEDICAL EXAMINER						DATE SIGNED Nov 17 1983	
EXAMINER'S NAME (TYPE OR PRINT) DR. JOHN S. ROGERS		ADDRESS 1919 Seminary Road; Silver Sp. Md							
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE Nov. 20, 83		23c. NAME OF CEMETERY OR CREMATORY Mt. Hebron Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Flushing; New York			
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEM. CHAPELS		ADDRESS 1170 Rockville Pike; Rockville, Maryland 20852		25a. DATE REC'D. BY REGISTRAR NOV 21 1983		25b. REGISTRAR'S SIGNATURE John J. Connel			

1947-1948

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30185

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HERBERT RUBIN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOV 15 1983</b>		2b. HOUR <b>11 P M</b>		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>NOV 25 1926</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>56</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3912 BEL TRE ROAD</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SECURITY</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>COUNTRY CLUBS</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONT.</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>		13d. STREET ADDRESS <b>3912 BEL TRE ROAD</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>DAVID RUBIN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MIRIAM UNKNOWN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII-KOREA 124-14-2908</b>		17. INFORMANT ADDRESS <b>MADELINE RUBIN SAME AS 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST.</b> 1539 DUE TO, OR AS A CONSEQUENCE OF (b) <b>METASTATIC COLON CARCINOMA.</b> 5 MONTHS DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION <b>9/3/83</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>COLON CANCER</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>AUGUST 3, 1983</b> to <b>11/16, 1983</b> , that (2) (we) lost saw the deceased alive on <b>10/20, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (2) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Alan J. Diamond</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>Nov 16, 1983</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALAN J. DIAMOND</b>		22e. ADDRESS <b>1106 SPRING ST. SILVER SPRING, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11-16-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MOUNT LEBANON</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>HYATTSVILLE P.G. MD.</b>	
24. FUNERAL DIRECTOR NAME <b>DM STEIN</b>		ADDRESS <b>2320 CARROLL ST WASH DC</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 21 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Goring</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

COLLIER

W. E. COLLIER

W. E. COLLIER

111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30786

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>COLBY GUEQUIERRE RUCKER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 13 1983</b>		2b. HOUR <b>9:43 am</b>
3. SEX <b>MALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 24 1903</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>80</b> YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MASSACHUSETTS</b>	7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. <b>BALTIMORE CITY OR</b> COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. NAVY</b>
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>ANNE ARUNDEL</b>	13c. CITY OR TOWN <b>ANNAPOLIS</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM COLBY RUCKER</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNETTE GUEQUIERRE</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>			16b. SOCIAL SECURITY NO. <b>1919-1949 212-34-7667</b>		17. INFORMANT ADDRESS <b>EMILY B. RUCKER, DOLPHIN IN THE WOOD, LINDAMOOD</b>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4151</b>		IMMEDIATE CAUSE (a). <b>PULMONARY EMBOLI COMPLICATING CHRONIC OBSTRUCTIVE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) _____		PULMONARY DISEASE			
DUE TO, OR AS A CONSEQUENCE OF (c) _____					

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 13, 1983</b> , to <b>NOVEMBER 13, 1983</b> , that (I) (we) lost saw the deceased alive on <b>NOVEMBER 13, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>David C. McClellan</i>		DEGREE		22c. DATE SIGNED <b>15 NOV 83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAVID C. MCLELLAN, LCDR, MC, USNR</b>		22e. ADDRESS <b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Nov. 17, 1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>U.S. Naval Academy, Annapolis</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>ANNAPOLIS MONTGOMERY MD</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Taylor Funeral Chapel - Annapolis, MD</b>			

RECEIVED  
JAN 10 1964

1964  
JAN 10 1964  
JAN 10 1964

1964  
JAN 10 1964  
JAN 10 1964



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 50M 4/82  
(VRA 15, 4)

#1, Film G586 12/1/83 kam

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30787  
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME FIRST MIDDLE LAST JUANITA JUANITA ELIZABETH RUSSELL		2a. DATE OF DEATH MONTH DAY YEAR 11-18-83		2b. HOUR 10 <sup>30</sup> P.M.	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR JULY 6 1908		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 907 Winhall Way		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES L. CHESSEX		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BILIE L. CHESSEX		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) None		16b. SOCIAL SECURITY NO. 577 40 0731A	
17. INFORMANT Same as 13E		17. ADDRESS 907 WINHALL WAY-SILVER SPRING		17. NAME OF HUSBAND Lee Wm. Russell (Husband)		17. ADDRESS Same as 13E	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CANCER OF COLON 1539 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 1/2 YEARS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION APRIL 1980		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CANCER OF COLON		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from APRIL 1980 to 11/18 1983, that (we) lost saw the deceased alive on 11/17 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE MARJORIE A. VOITH MD	
22c. DATE SIGNED 11/19/83		22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARJORIE A. VOITH MD		22e. ADDRESS 106 IRVING ST. NW WASHINGTON, DC 20010		22f. DEGREE MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/22/83		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Maryland	
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home		24. ADDRESS 11800 New Hampshire Ave Silver Spring Md.		25. DATE REC'D. BY REGISTRAR NOV 22 1983		25. REGISTRAR'S SIGNATURE John J. Carver	

MEDICAL CERTIFICATION



17-00000 11800 New Hampshire Ave  
1231 3rd St NW  
Washington, D.C. 20004

BP

DHMH-16 30M 2/80  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR		30 / 88				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NANCY C. RUTTER					2a. DATE OF DEATH MONTH DAY YEAR NOV. 10 1983			2b. HOUR 2 P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 22 1916		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4450 South Park Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Chevy Chase					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4450 South Park Ave. 20815		
14. FATHER'S NAME FIRST MIDDLE LAST Charles -- Comstock					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen --- Spencer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --		17. INFORMANT Son Steve Rutter		ADDRESS Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Insufficiency</u> 1509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Carcinoma</u> (c) <u>Carcinoma of Esophagus</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>months</u> <u>months</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>4/17</u> 19 <u>83</u> , to <u>11/10</u> 19 <u>83</u> , that (I) (we) lost the deceased alive on <u>11/10</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Norman A. Odyniec M.D.				DEGREE M.D.				22c. DATE SIGNED Nov. 10, 1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Norman A. Odyniec M.D.				22e. ADDRESS 3301 New Mexico Ave. N.W. Wash. D.C.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE Nov. 11, 1983		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia			
24. FUNERAL DIRECTOR NAME DeVol Funeral Home Robert A. DeVol				ADDRESS 2222 Wisc Ave. Wash. D.C.		25a. DATE REC'D. BY REGISTRAR NOV 16 1983		25b. REGISTRAR'S SIGNATURE John J. Conner	





1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30 / 89

1. DECEASED NAME (TYPE OR PRINT) JESSE J. SABO Sr.			2a. DATE OF DEATH MONTH DAY YEAR 11-3-83			2b. HOUR 0630 M.			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Oct. 17, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSP				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Home Builder	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 12503 Farnell Drive 20906	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Sabo					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Harriett Jierre				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 183 05 9489		17. INFORMANT ADDRESS Helen J. Sabo Wife Same as item 13					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Shock  
DUE TO, OR AS A CONSEQUENCE OF  
(b) Carcinoma of the Lung  
DUE TO, OR AS A CONSEQUENCE OF  
(c) \_\_\_\_\_

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

sudden

4 months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: \_\_\_\_\_

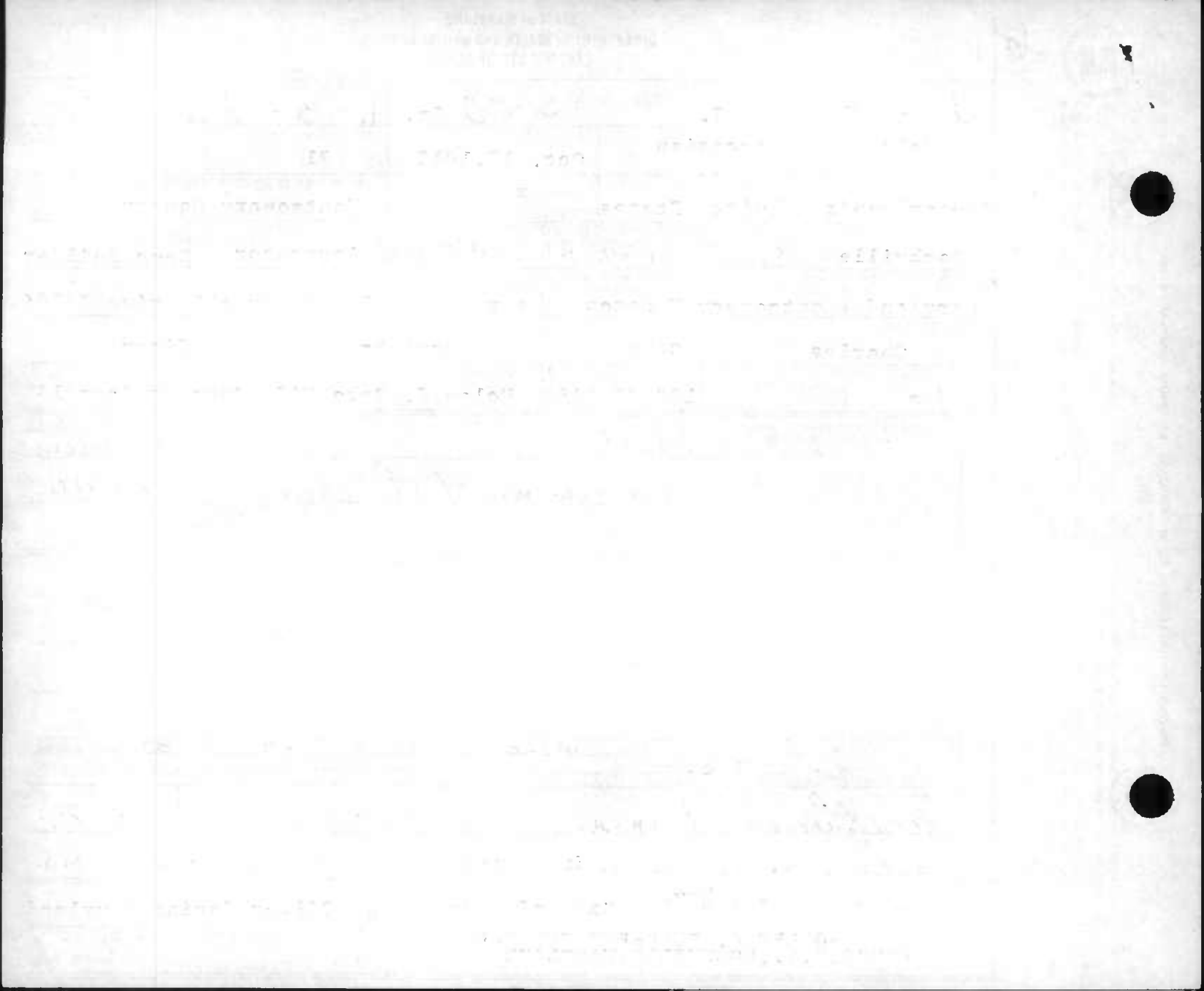
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>10/28</u> , 19 <u>83</u> , to <u>11/3</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>11/2/83</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Elba J. Martinez, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-3-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ELBA J. MARTINEZ, M.D.				22e. ADDRESS 8808 HIDDEN HILL LA. - POTOMAC MD.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 5, 1983		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND				25a. DATE REC'D. BY REGISTRAR NOV 7 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.





RECEIVED  
FEB 10 1968  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

MEMORANDUM FOR THE RECORD  
SUBJECT: [Illegible]  
DATE: [Illegible]  
FROM: [Illegible]  
TO: [Illegible]  
[Illegible text follows]

11

[Illegible handwritten notes and signatures]

Very truly yours,  
[Illegible signature]  
[Illegible text]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30791

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTH DAY YEAR	
ROSE		11 11 83		12:45 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	Caucasian	MONTH DAY YEAR	58 YRS.	IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Washington, D.C.	U.S.A.		MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring	Holy Cross Hospital	Secretary	Mont. Cty. Schools		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	Montgomery	Silver Spring	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	9517 Caroline Avenue 20901	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
First MIDDLE LAST	First MIDDLE LAST	16b. SOCIAL SECURITY NO.			
Rosario	Vezzi	577-32-7454			
17. INFORMANT		17. ADDRESS			
Josephine		DiGregorio			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:					
1539 IMMEDIATE CAUSE (a) Carcinoma of Colon & Metastases					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
	P.M. 19				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION			
		CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Jan 19 80 to Nov 11 19 83, that (I) (we) lost saw the deceased alive on Nov 11 19 83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
BERNARD A. FITZGERALD		M.D.		11-11-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. REGISTRAR'S SIGNATURE	
Bernard A. Fitzgerald		277 University Blvd East, Silver Spring, Md		John J. Conner	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
Burial	Nov. 14, 1983	Gate of Heaven	Silver Spring Mont. Md.		
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Francis J. Collins		NOV 17 1983		John J. Conner	
500 University Blvd., W. Silver Spring, Md.					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers Pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 50M 4/B2  
(VRA 15, 4)1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH30792  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Benedicta Salmon</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-17-83</b>		2b. HOUR <b>11 P.M.</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sep. 18, 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>86</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Roumania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Potomac Valley Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Owner (Ret.)</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Real Est. Co</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Max Goldner</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Frances Ginger</b>		13e. STREET ADDRESS <b>8303 Still Spring Court</b>		20817	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>076-20-2656</b>		17. INFORMANT ADDRESS <b>Thelma Simms; 8303 Still Spring Court</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHRONIC ORGANIC BRAIN SYNDROME</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>GENERALIZED ARTERIOSCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>CARCINOMA OF THE LUNG</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>JAN. 19, 1983</b> to <b>NOV. 17, 1983</b> , that (I) (we) last saw the deceased alive on <b>OCT. 24, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>R.C. Taddario MD</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/17/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R.C. TADDARIO</b>		22e. ADDRESS <b>5413 CEDAR LANE BETHESDA MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>11-18-1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR NAME <b>Danzansky-Goldberg Chapels; 1170 Rockville Pike</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 21 1983</b>		25b. REGISTRAR'S SIGNATURE <b>Sam J. Gail</b>			

MEDICAL CERTIFICATION

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

*[Faint, illegible text at the bottom of the page]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

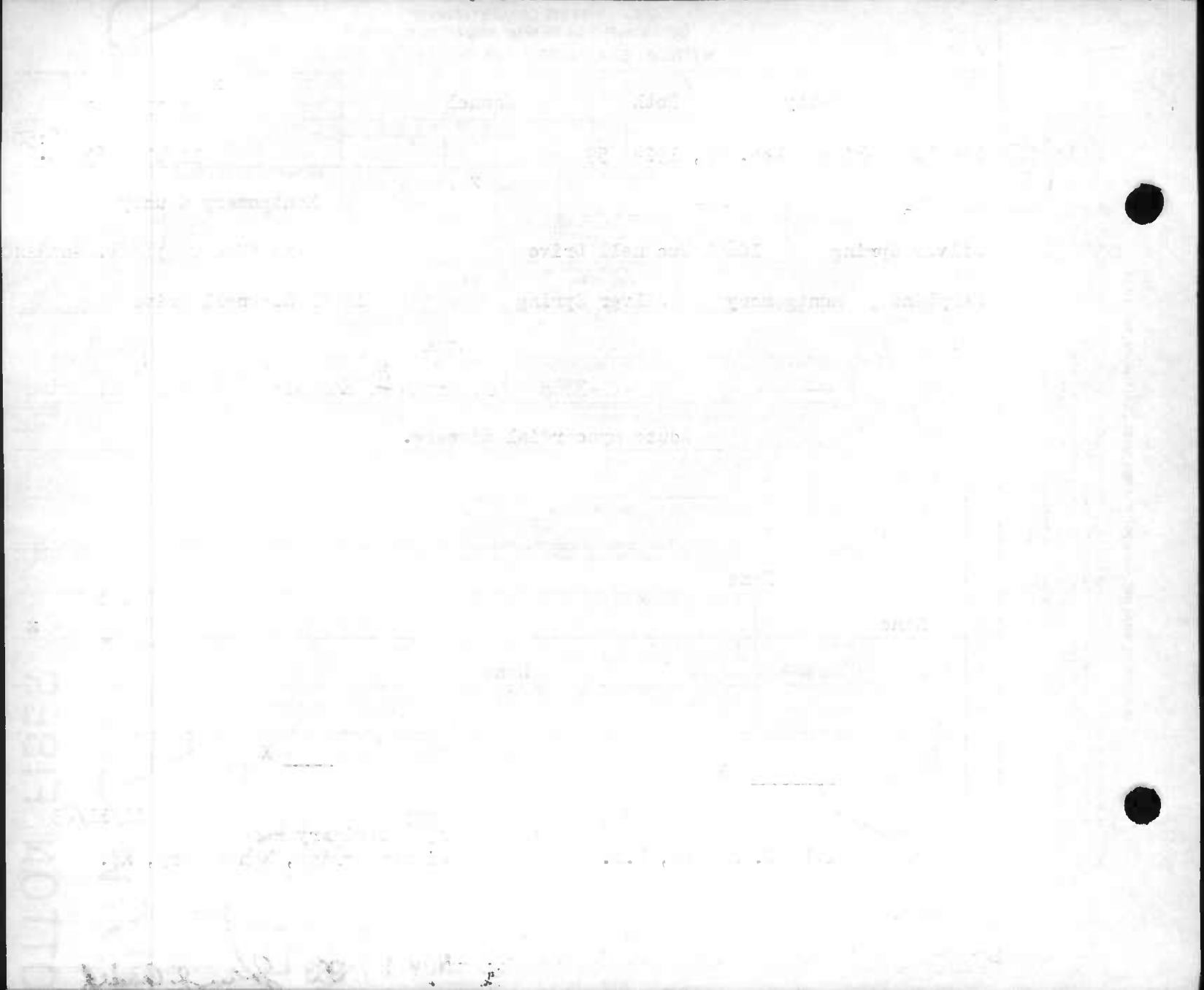
DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

30793

1- STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Betty Roth Samuel</b>										DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11/11 1983</b>		HOUR <b>8:50 A.</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH (MONTH DAY YEAR) <b>Feb. 15, 1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD <b>11/11 1983</b>		2d. HOUR <b>8:50 A.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Indiana</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b>	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>10861 Bucknell Drive</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Economist (Retired)</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Intl. ResAssoc</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>10861 Bucknell Drive 20902</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Roth</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lena Mentzel</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>303-22-3208</b>		17. INFORMANT <b>H. Wheaton, Md., 20902</b> <b>Dr. Aryeh S. Samuel; 10861 Bucknell Drive</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>Acute myocardial disease.</b> IMMEDIATE CAUSE (a) <b>4291</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>None</b>													
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>None</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <b>John S. Rogers, M.D.</b>				TITLE (SPECIFY) <b>Deputy</b>				MEDICAL EXAMINER <b>1919 Seminary Road</b>				DATE SIGNED <b>11/11/83</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>				ADDRESS <b>Silver Spring, Montgomery, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>11-13-1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Judean Memorial Gardens</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Olney, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Danzansky-Goldberg Chapels;</b>				ADDRESS <b>1170 Rockville Pike</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 17 1983</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Givens</b>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH		DAY		YEAR		2b. HOUR			
Joyce Sands								<input checked="" type="checkbox"/>		11		24		1983		M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR			
Female		Black		Aug 25 1934		49 YRS.						11		24		1:58 a.m.			
7a. BIRTHPLACE (STATE OR COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland				U.S.A.								Montgomery County, MD.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Onley				Montgomery General Hospital				Pulmonary Tech. Hospital											
13a. STATE								13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS					
Maryland								Howard		Woodbine		YES		15088 Frederick Rd. 21797					
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST															
Leslie Winslow				Carlene Dunkins															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT											
				217-30-4352				Dellhne I Monroe, Randallston											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <u>Sickle cell crisis</u> IMMEDIATE CAUSE (a) <u>2826</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <u>Margarete A. Korell</u>								TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED <u>11-25-83</u>							
EXAMINER'S NAME (TYPE OR PRINT) <u>Margarita A. Korell, M.D.</u>								ADDRESS <u>111 Penn Street</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN				23e. COUNTY					
Burial				11-28-83		Arbutus Mem. Park				Arbutus				Baltimore Md					
24. FUNERAL DIRECTOR NAME								*ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Harvey W Haight								Sykesville				NOV 28 1983				John J. Grier			

BP 374

10

THE  
OFFICE OF THE  
SECRETARY OF THE  
NAVY  
WASHINGTON, D. C.  
JAN 10 1900

RECEIVED  
JAN 10 1900



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/82  
(VRA 15, 4)

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30795

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MERRILL HOMER SAPPINGTON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 28 1983</b>		2b. HOUR <b>6:30 P.M.</b>		
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>SEPTEMBER 30 1920</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <b>63</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>GEORGIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. NAVY</b>	
13a. STATE <b>VIRGINIA</b>		13b. COUNTY <b>FAIRFAX</b>		13c. CITY OR TOWN <b>MCLEAN</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>HOMER ARTHUR SAPPINGTON</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ALLIE ELIZABETH MEANS</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>1942-1975</b>	
17. INFORMANT ADDRESS <b>KATHRYN B. SAPPINGTON, 6345 MUNHALL COURT,</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ADENOCARCINOMA OF THE LUNG</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>1629</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 7, 1983</b> , to <b>NOVEMBER 28, 1983</b> , that (I) (we) last saw the deceased alive on <b>NOVEMBER 28, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>J.P. Asher</i>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>30 Nov 83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JEANNE P. ASHER, LT, MC, USNR</b>		22e. ADDRESS <b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/5/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Murphy Funeral Home/4510 Wilson Blvd. Arlington, VA</b>				25a. DATE REC'D BY REGISTRAR <b>DEC 5 1983</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Lohr</i>	

999999



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30796

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME FIRST MIDDLE LAST 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR

(TYPE OR PRINT)

3. SEX

4. RACE

5. DATE OF BIRTH

6. AGE (IN YEARS LAST BIRTHDAY)

IF UNDER 1 YEAR

IF UNDER 24 HRS

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

10. CITY OR TOWN OF DEATH

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

13b. COUNTY

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS?

13e. STREET ADDRESS

14. FATHER'S NAME

FIRST

MIDDLE

LAST

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

17. INFORMANT

ADDRESS

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b) Squamous cell CA in abd/perna

DUE TO, OR AS A CONSEQUENCE OF (Resection of)

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1952

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

Gastrointestinal Bleeding; Stress Ulcers

1 day

1 yr

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Renal failure, Hepatic Insufficiency, Urinary infection

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

WHILE ☐ NOT WHILE ☐ AT WORK AT WORK

22a. I certify that (1) (this hospital) attended the deceased from 11/19/83 to 11/19/83, that (1) (we) lost saw the deceased alive on 11/19/83, and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

24. FUNERAL DIRECTOR

25a. DATE REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

CHAMBERS FUNERAL HOME SILVER SPRING, MD NOV 25 1983

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

Hand Book

DOI 10.1002/for

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30797

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Louis Boyd Scales			2a. DATE OF DEATH MONTH DAY YEAR 11-14-83		2b. HOUR 6:27 a.m.
3. SEX male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 11 14 83		6. AGE (IN YEARS LAST BIRTHDAY) 110 minutes	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 1 50
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD		13b. COUNTY Mont.	13c. CITY OR TOWN S.S.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Z.achariah Scales		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Burdelle Boyd			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT Mother's Medical Record	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 7650 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Non-Viable Infant</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Extreme Prematurity (21 weeks gest)</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18a					
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) N/A	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A	
22a. I certify that (I) (this hospital) attended the deceased from <u>11-14</u> , 19 <u>83</u> , to <u>11-14</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on _____, 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>L F Cohen MD</u>		DEGREE		22c. DATE SIGNED 11/14/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lawrence F. Cohen, MD		22e. ADDRESS Washington Adventist Hosp, Takoma Park, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D BY REGISTRAR NOV 25 1983	
				25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

BP

8837 S. VON

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30198

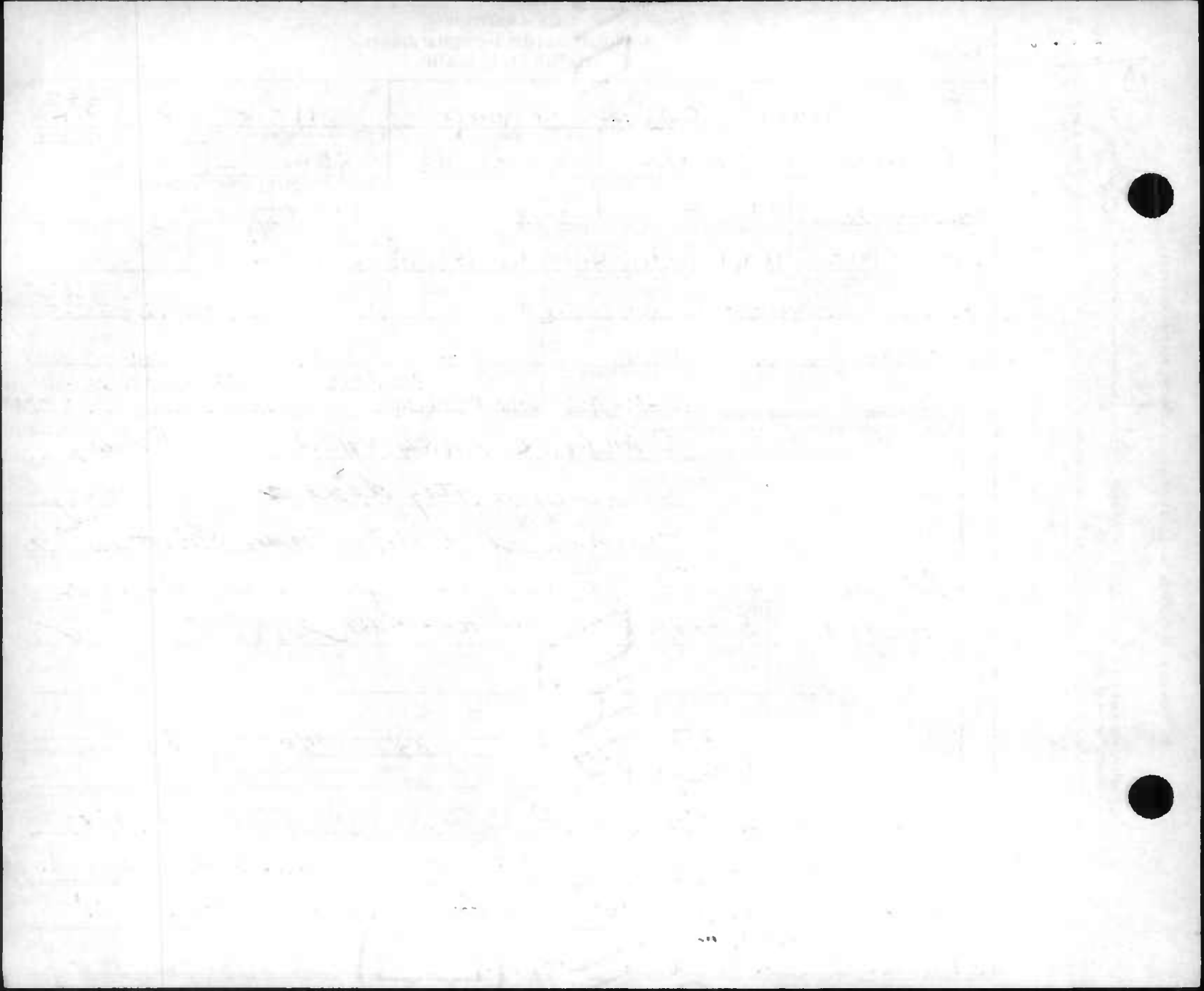
1. FOR STATE REGISTRAR			2a. DATE OF DEATH			2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST			MONTH DAY YEAR			HOUR MIN.		
Mary Caroline Schaub			11-6-83			3:57 A.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Female	White	MONTH DAY YEAR	80 yr			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Pennsylvania		U.S.A.				Montgomery MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Jakom Park	Washington Adventist Hospital		Retired					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
13a. STATE 13b. COUNTY 13c. CITY OR TOWN			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20904		
Maryland Montgomery Silver Spring						11700 Old Columbia Pike # 1-3		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			ADDRESS		
FIRST MIDDLE LAST			FIRST MIDDLE LAST					
Abraham B. Landis			Mary E. Madden					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT		
No			215-46-0708			Daughter Gene Heinbaugh		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY:			hours					
IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF					
4149			Cranial artery disease			years		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)					
			DUE TO, OR AS A CONSEQUENCE OF			years		
			Generalized arteriosclerosis obliterans					
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:								
Renal Failure, Liver Failure, Heart Failure								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		
11/4/83			BLEEDING ESOPHAGEAL VARICES			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED		
			HOUR A.M. MONTH DAY YEAR			(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 11/2 1983, to 11/6 1983, that (I) (we) last saw the deceased alive on 11/6 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not view the body after death.)								
23a. SIGNATURE			DEGREE			22c. DATE SIGNED		
Kenneth Cruze, M.D.						11/7/83		
23b. PHYSICIAN'S NAME (TYPE OR PRINT)			22a. ADDRESS					
Kenneth Cruze, M.D.			831 University Blvd., E. Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
Burial			Nov. 9, 1983			Parklawn Cemetery		
23d. LOCATION			23e. CITY OR TOWN			23f. COUNTY		
Rockville			Mont.			Md.		
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
NAME ADDRESS			NOV 14 1983			John J. Connel		
Francis J. Collins			500 University Blvd. W. Silver Spring, Md.					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

30799

FOR - STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) <i>Martha M. Scheble</i>		2a. DATE KNOWN OF DEATH <i>Nov 19, 1983</i>		2b. MONTH DAY YEAR		2c. DATE PRONOUNCED DEAD <i>Nov 19, 1983</i>		2d. MONTH DAY YEAR		2e. DATE PRONOUNCED DEAD <i>Nov 19, 1983</i>		2f. MONTH DAY YEAR					
3 SEX <i>F</i>		4 RACE <i>W</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>May 5, 1882</i>		6 AGE (IN YEARS) LAST BIRTHDAY <i>101</i> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Wash. D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery MD.</i>		10. CITY OR TOWN OF DEATH <i>Olney</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Montgomery General Hosp</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Women Commonwealth of D.C.</i>		12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE <i>MD.</i>		13b. COUNTY <i>Montgomery</i>					
13c. CITY OR TOWN <i>Sierra</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>20904 N. Hamp. Ave</i>		14. FATHER'S NAME FIRST MIDDLE LAST <i>UNK Scheble</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Gertrude UNK</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>None</i>		16b. SOCIAL SECURITY NO. <i>220 44 0865</i>		17. INFORMANT ADDRESS <i>2337 California St. Wash. D.C. Woodson Houghton (Attorney)</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: <i>8809</i> IMMEDIATE CAUSE (a) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>Fracture L hip</i>																			
19a. DATE OF OPERATION <i>Oct. 30, 83</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>Fracture L hip</i>		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>10:24 11 83</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>Fell down stairs at home</i>		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Home</i>		21f. LOCATION CITY OR TOWN COUNTY STATE <i>N. Hamp. Ave. S. S. Md.</i>			
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																			
ACTUAL SIGNATURE <i>John S. Rogers</i>		TITLE (SPECIFY) <i>MD. Reg</i>		MEDICAL EXAMINER		DATE SIGNED <i>Nov 24, 1983</i>		EXAMINER'S NAME (TYPE OR PRINT) <i>John S. Rogers</i>		ADDRESS <i>1919 Seminary Rd. S.S. Md.</i>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>11/29/83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Wash. D.C.</i>	
24 FUNERAL DIRECTOR NAME <i>Hines/Rinaldi</i>		ADDRESS <i>11800 New Hampshire Ave. S.S. Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>NOV 23 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Conish</i>													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 50M 1/81  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30800

1 - FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>Helen M. Scheffer</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>November 28, 1983</b>		2b. HOUR <b>10:45a M</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 7, 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>National Lutheran Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerical worker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Scheffer</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Schisler</b>		13e. STREET ADDRESS <b>4304 Arabia Ave.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>212-74-7341</b>		17. INFORMANT <b>Rev. Richard Reichard</b>		ADDRESS <b>9701 Veirs Dr. Rockville Md.</b>	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>41401 Renal failure</b> IMMEDIATE CAUSE (a) <b>Renal failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Nephrosclerosis.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>arteriosclerotic Heart Disease</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) <b>arteriosclerotic Heart Disease</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept. 29, 1983</b> to <b>Nov. 28, 1983</b> , that (I) (we) last saw the deceased alive on <b>Nov. 28, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>HAROLD F. McCANN</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-28-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HAROLD F. McCANN</b>		22e. ADDRESS <b>3355 16th St. N.W. WASH. D.C. 20010</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 30, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>The Hysong Co. 1300 N St. N.W. Washington, D.C.</b>				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "other," it must be certified by the medical examiner.

MEDICAL EXAMINER NOTIFIED AND RELEASED

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 30801	
1. DECEASED NAME (PRINT) <b>ROBERT G. SCHMIDT</b>			2a. DATE OF DEATH <b>NOVEMBER 29, 1983</b>			2b. HOUR <b>12:25 AM</b>					
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>MAY 31, 1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD.</b>					
10. CITY OR TOWN OF DEATH <b>KENSINGTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>9623 CULVER STREET</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>GEOLOGIST</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOVT.</b>			
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>KENSINGTON</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>9623 CULVER ST. 20895</b>			
14. FATHER'S NAME FIRST <b>KARL</b> MIDDLE <b>PATTERSON</b> LAST <b>SCHMIDT</b>				15. MOTHER'S MAIDEN NAME FIRST <b>MARGARET</b> MIDDLE <b>WIGHTMAN</b> LAST <b>WIGHTMAN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>WWII 217-44-0251</b>		17. INFORMANT ADDRESS <b>JESSICA W. SCHMIDT, WIFE, KENSINGTON, MD. 9623 CULVER ST.,</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Chronic Obstructive Lung Disease</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>8/82</b> , 19____, to <b>11/29/83</b> , 19____, that (I) (we) lost saw the deceased alive on <b>11/2/83</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Jeremy V. Cooke, MD</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/29/83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JEREMY V. COOKE M.D.</b>						22e. ADDRESS <b>10400 CONN. AVE., KENSINGTON, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>12/1/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>QUANTICO NAT. CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>QUANTICO PR. WM. VA.</b>				
24. FUNERAL DIRECTOR NAME <b>RICHARD RAPP, INC.</b> ADDRESS <b>1120 CONN. AVE., N.W. #940, WASH., D.C. 20036</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 2 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Gansh</b>			

BP \_\_\_\_\_



RECEIVED  
JAN 21 1952  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.  
OFFICE OF THE SECRETARY  
MAIL ROOM  
JAN 21 1952  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										30802 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Leo W. Scott</b>							2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>11 27 83</b>		2b. HOUR P M <b>2 34</b>		
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>3 2 09</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>74</b> YRS.	IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>	IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>11 27 83</b>		2d. HOUR P M <b>2 34</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUBURBAN HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PHYSICIST</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>N.B.S.</b>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Md.</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>CHEVY CHASE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>20815 5100 DORSET AVE #104</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>FRED HYNDS SCOTT</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>EIMA E. OSTERHOUT</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>578-28-6320</b>		17. INFORMANT NAME ADDRESS <b>GUINEVERE SCOTT (WIFE) SEE ITEM #13</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4140 Cardiac arrest</b> IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>coronary arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>John Taylor</b> EXAMINER'S NAME (TYPE OR PRINT)				TITLE (SPECIFY) <b>Deputy</b> M.D. MEDICAL EXAMINER				DATE SIGNED <b>11-27-83</b>			
ADDRESS <b>8218 Wisconsin Ave Bethesda</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>				23b. DATE <b>11/28/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LEE CREMATORY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>WASHINGTON, D.C.</b>			
24. FUNERAL DIRECTOR <b>J. WILLIAM LEE'S SONS COMPANY</b> <b>300 4th St. NE WASH., D.C. 20002</b>						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>John J. Givish</b>			

DEC - 2 1983



NEW YORK

UNITED STATES

PHYSICIAN

SUBURBAN HOSPITAL

PHYSICIST

NO.

MONTGOMERY CHEVY CHASE

20815  
3100 DIXIE AVE #104

REED

HYMS

SCOTT

WMA

E.

OUTREACH

NO

578-38-6350

SEE ITEM #13

CHURCHMAN SCOTT (LFT)

300 4th St. NW Wash., D.C. 20002  
J. WILLIAM LINDSAY JR. COMPANY  
CREATION 11/26/83  
J. WILLIAM LINDSAY JR. COMPANY  
WASHINGTON, D.C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Possession may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30803

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Gertrude L. SEATON</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>November 14, 1983</i>		2b. HOUR <i>2051 P.M.</i>	
3. SEX <i>Female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>June 15, 1901</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>82</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.
10. CITY OR TOWN OF DEATH <i>Rockville</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Shady Grove Adventist Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>home</i>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Unknown Smith</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Unknown Livingston</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>no</i>		
16b. SOCIAL SECURITY NO. <i>578-10-5681</i>		17. INFORMANT ADDRESS <i>Maryland 20851</i> <i>Thomas Seaton, Jr. 1411 Bradley Ave. Rockville,</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Arrest.</i> <i>4140</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>1 year</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>11/1/82</i> to <i>11/14/83</i> , that (I) (we) last saw the deceased alive on <i>11/14/83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Robert C. Macon</i> PHYSICIAN'S NAME (TYPE OR PRINT)		DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11/15/83</i>
22d. ADDRESS <i>Robert C. Macon</i>		22e. ADDRESS <i>809 Viers Mill Rd. Rockville, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>		23b. DATE <i>11/17/83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Memorial Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Rockville, Maryland</i>
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home, Inc.</i> NAME ADDRESS <i>1331 Rockville Pike Rockville, Md. 20852</i>				25a. DATE REC'D. BY REGISTRAR <i>NOV 18 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 30804			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>RENA SELIGER</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 12, 1983</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 1, 1913</b>		2b. HOUR <b>1:00p.m.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash., D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS <b>70 YRS.</b>		8. IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1811 Arcola Avenue; SSpg, Md</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Schoolteacher (Ret) School</b>				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Sil.Spg.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Norman</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah Funger</b>		17. STREET ADDRESS <b>1811 Arcola Avenue</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>578-01-3293</b>		17. INFORMANT <b>Silver Spring, Md. Robert Seliger; 1811 Arcola Avenue</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1830</b> <b>Intoxication</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Intestinal Obstruction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Adenocarcinoma of Ovary</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b> <b>3 months</b> <b>1 year</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>4-7</b> , 19 <b>81</b> , to <b>11/12</b> , 19 <b>83</b> , that (I) <b>first</b> saw the deceased alive on <b>11/12</b> , 19 <b>83</b> , and that in (my) <b>last</b> opinion death occurred on the date and hour and from the causes stated above; (I) <b>we</b> <b>did not</b> view the body after death.							
22b. SIGNATURE <b>G. Lennard Gold, M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>11-12-1983</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G. LENNARD GOLD, M.D.</b>				22e. ADDRESS <b>8630 Fenton Street; Silver Spring, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-14-1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King David Mem. Garden</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Falls Church, Virginia</b>	
24. FUNERAL DIRECTOR NAME <b>Danzansky-Goldberg Chapels; 1170 Rockville Pike</b>				25. REGISTRAR'S SIGNATURE <b>John J. Canfield</b>			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30805

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Lucile Shafor</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 18, 1983</b>		2b. HOUR pm <b>10:30</b>		
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 22, 1883</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>100</b> YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carriage Hill Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Never Employed</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Kensington</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Shafor</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Anderson</b>		16. STREET ADDRESS <b>10311 Freeman Place</b>		Zip: <b>20895</b>	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE YEAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216-46-8183</b>		17. INFORMANT (Friend) <b>Charles Hollowell, Kensington, MD</b>		ADDRESS <b>10311 Freeman P1.</b>	
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18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>4275</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**OLD AGE**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
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21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
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22a. I certify that (I) (this hospital) attended the deceased from **about 11-18**, 19 **83**, to **11-18**, 19 **83**, that (I) (we) last saw the deceased alive **above**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <b>Richard H. Pullen</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-19-83</b>	
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RICHARD H. PULLEN MD</b>		22e. ADDRESS <b>10400 Connecticut Ave, KENSINGTON MD</b>	
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>NOV. 21, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodside Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Middletown Ohio</b>	
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24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 21 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



10/20/20



**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

REG. NO.

3 0 8 0 6

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
I. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		11 2 83		4:00AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
MALE		WHITE		JULY 31, 1905		78	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
MD.		USA				Montgomery MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Olney		Montgomery General Hospital		House Painter		Painting	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS	
Md. 21771		FREDERICK		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13954 Prospect Ave. 21771	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Nathen E. Sheckels		Edith M. BOWEN		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		217-01-4678	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
MICHAEL J. SHECKELS		1850 IMMEDIATE CAUSE (a) Adenocarcinoma of PROSTATE, WIDELY METASTATIC		YEARS -			
SAME AS # 13		(b) DUE TO, OR AS A CONSEQUENCE OF RENAL FAILURE SECONDARY TO DX # A		3 MONTHS			
		(c) DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 79, to NOV 2, 19 83, that (I) (we) last saw the deceased alive on NOV 2, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
Eugene P. Flannery MD		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		11/2/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. CITY OR TOWN		22g. COUNTY	
EUGENE P. FLANNERY, MD		1811 PRINCE PHILIP DR. OLNEY, MD. 20832					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		NOV. 4, 1983		DAMASCUS		DAMASCUS MONT. MD.	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
FRANCIS H. BARBER LAYTONSVILLE, MD. 20879				NOV 7 1983		John J. Connel	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



20% COTTON FIB

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30807

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>MARGARET (NMN) SHEPP</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>11 4 1983</i>		2b. HOUR <i>8 PM</i>	
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>October 9, 1908</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>75</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Scotland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County MD.</i>
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Home maker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Pr. George's</i>	13c. CITY OR TOWN <i>Glenn Dale</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>James McAlister</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Margaret Stevenson Dillon</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>		16b. SOCIAL SECURITY NO. <i>198-05-0660</i>		17. INFORMANT ADDRESS <i>Mrs. Margaret S. Hyatt 9921 Worrell Avenue Glenn Dale, MD 20769</i>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *CARDIO-PULMONARY ARREST*  
 DUE TO, OR AS A CONSEQUENCE OF  
 (b) *RESPIRATORY FAILURE*  
 DUE TO, OR AS A CONSEQUENCE OF  
 (c) \_\_\_\_\_

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH*6 months.*

## PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

*CORONARY ARTERY DISEASE*

19a. DATE OF OPERATION <i>4-14-83</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Coronary Artery Disease</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>13 April 1983</i> to <i>14 Nov. 1983</i> , that (I) <del>last</del> saw the deceased alive on <i>14 Nov 1983</i> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>do</del> (did not) view the body after death.							
22b. SIGNATURE <i>Michael Schwartz</i>		DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>5 Nov. 83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MICHAEL SCHWARTZ</i>				22e. ADDRESS <i>5711 SARVIS Ave #316 Riverdale, Md 20739</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Nov 8, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>North Cedar Hill Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Philadelphia, Philadelphia, PA</i>	
24. FUNERAL DIRECTOR NAME <i>Beall Funeral Home</i> ADDRESS <i>16000 Annapolis Road Bowie, Maryland 20715</i>				25a. DATE REC'D. BY REGISTRAR <i>NOV 7 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Linnick</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a necropsy performed.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30808

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTH DAY YEAR	
Cora Lee Shippellett		November 19, 1983		10 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	White	MONTH DAY YEAR	85	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Virginia	U.S.A.	Montgomery	MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring	10125 Tenbrook Drive	Nurse			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
Maryland	Montgomery	Silver Spring	YES <input type="checkbox"/> NO <input type="checkbox"/>	10125 Tenbrook Drive 20901	
14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		
Houston Morris	Florence UNKNOWN		16b. SOCIAL SECURITY NO. N/A		
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> 4850 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>November 1, 1983</u> to <u>Nov 19, 1983</u> , that (I) (we) last saw the deceased alive on <u>Nov 17, 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.		22b. SIGNATURE <u>Morton A. Chschuler M.D.</u>		22c. DATE SIGNED 11/19/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	
Morton A. Chschuler M.D.		1288 - Lambert Ave. Silver Spring, Md. 20902		Burial	
23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Nov. 22, 1983		Evergreens Cemetery		Standardsville - Green Virginia	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Francis J. Collins		NOV 25 1983		John J. Carver	
26. ADDRESS		27. ADDRESS			
500 Univ. Blvd. W., Silver Spring, Md.					

1154

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

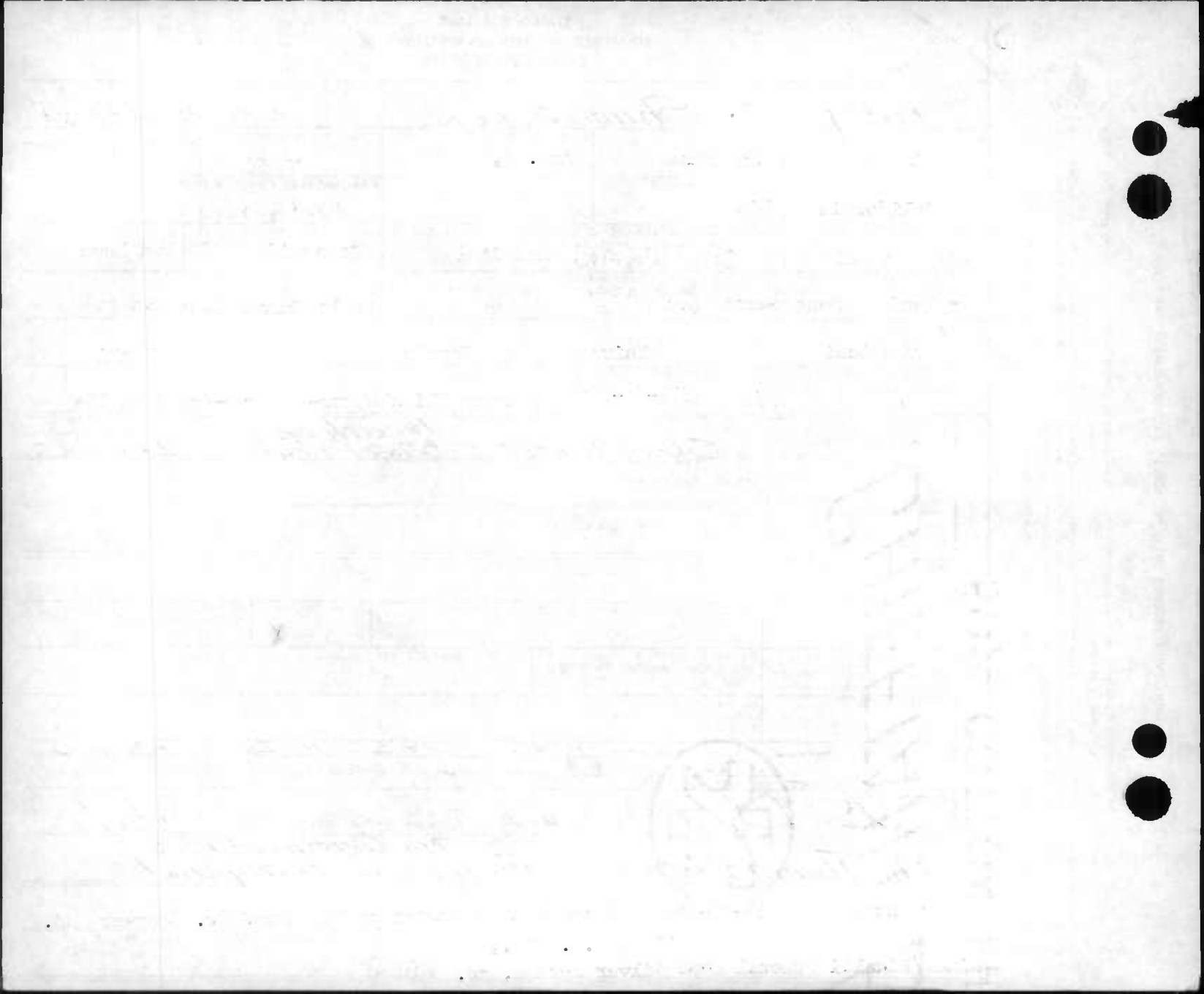
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				30809			
FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>ARMY Y. Shimabukuro</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>Nov 26, 1983</i>		2b. HOUR <i>2:20 P.M.</i>	
3. SEX <i>female</i>		4. RACE <i>Japanese</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Aug. 5, 1927</i>		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS. <i>56</i> YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>California</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>SUBURBAN Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>				13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Potomac</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Kukukichi Taira</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Hanako Uechi</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>N/A</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>N/A</i>		17. INFORMANT ADDRESS <i>Kaoru Shimabukuro-husband-(same as 13e)</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Spontaneous subarachnoid Hemorrhage</i> <i>4300</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>22 hours</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>11/25</i> , 19 <i>83</i> , to <i>11/26</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>11/26</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>John Thomas</i>				DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>11/26/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John Thomas</i>				22e. ADDRESS <i>1910 Woodmont Ave Bethesda, Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>11-30-1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Crematory</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Brentwood Pr. Georges Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Hines/Rinaldi Funeral Home Silver Spring, Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>NOV 28 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Lohr</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 30810				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Franklin Bernell Shores</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>11 29 83</b>			2b. HOUR <b>12:04a m</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>03 20 24</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>59 years</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Mississippi</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Pepsi-Cola</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Rockville</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4701 Coachway Drive 20852</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>David Shores</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Callie Hodge</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. (IF THIS WAS WAR OR DATES) <b>WW II 426-14-0066</b>		17. INFORMANT ADDRESS <b>Joan K. Shores same as 13e</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Adenocarcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Adenocarcinoma of Stomach</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>1519</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>few mos.</b> <b>6 mos.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <b>5/22, 19 83</b> to <b>11/29 19 83</b> , that (I) (we) last saw the deceased alive on <b>11/28 19 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <b>G. Lennard Gold, M.D.</b> DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED <b>11/29/83</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G. Lennard Gold</b>					22e. ADDRESS <b>8630 Fenton Street Silver Spring, Md. 20910</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/5/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Knights of Pythias Cemetery</b>		23d. LOCATION (CITY OR TOWN, COUNTY, STATE) <b>Elizabeth, W. Va. STATE</b>			
24. FUNERAL DIRECTOR'S NAME (TYPE OR PRINT) <b>Trayson Wheeler Funeral Home, Inc.</b>					25a. DATE REC'D. BY REGISTRAR <b>DEC 5 1983</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Lough</b>		
24. ADDRESS <b>1331 Rockville Pike Rockville, Md. 20852</b>									

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30811

1. FOR  
STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Nadassah

Shuler

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

Nov 12, 1983

10 16 AM

3. SEX

Female

4. RACE

Black

5. DATE OF BIRTH

MONTH

DAY

YEAR

Nov 18 1963

6. AGE (IN YEARS LAST BIRTHDAY)

19

IF UNDER 1 YEAR

MONTHS

IF UNDER 24 HRS

HOURS

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Washington, D.C.

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Takoma Park (Montgomery)

MD.

10. CITY OR TOWN OF DEATH

Takoma Park

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

Washington Adventist Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Clerk

12b. KIND OF BUSINESS OR INDUSTRY

Unknown

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Wash., D.C.

13b. COUNTY

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

4331 Kansas Ave., N.W. 99999

14. FATHER'S NAME

Elisha

MIDDLE

Shuler

15. MOTHER'S MAIDEN NAME

Mymie

MIDDLE

Ashford

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

16c. SOCIAL SECURITY NO.

579-86-5171

17. INFORMANT

ADDRESS

Mymie Shuler 4331 Kansas Ave., N.W., Wash., D.C.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

5713

IMMEDIATE CAUSE (a)

RESPIRATORY FAILURE

DUE TO, OR AS A CONSEQUENCE OF

(b) GASTROINTESTINAL BLEEDING

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c) CHRONIC LIVER DISEASE

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

SEVERE COAGULO PATHY

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☒ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED  
WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING  
PHYSICIAN ☒MEDICAL  
DIRECTOR ☐STAFF  
PHYSICIAN ☐

22c. DATE SIGNED

11/12/83

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

KEMPANNA SUDHAKAR

22e. ADDRESS

7626 NEW HAMPSHIRE AVE.  
LANGLEY PARK, MD 20783

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

11-16-83

23c. NAME OF CEMETERY OR CREMATORY

Harmony Cemetery

23d. LOCATION

CITY OR TOWN

Landover, Maryland

STATE

24. FUNERAL DIRECTOR

Vann &amp; Williams, 4804 Ga. Ave., N.W., Wash., D.C.

25a. DATE REC'D. BY REGISTRAR

NOV 21 1983

25b. REGISTRAR'S SIGNATURE

Cleared to mail

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page. The text appears to be organized into several paragraphs and possibly a list or table structure.]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

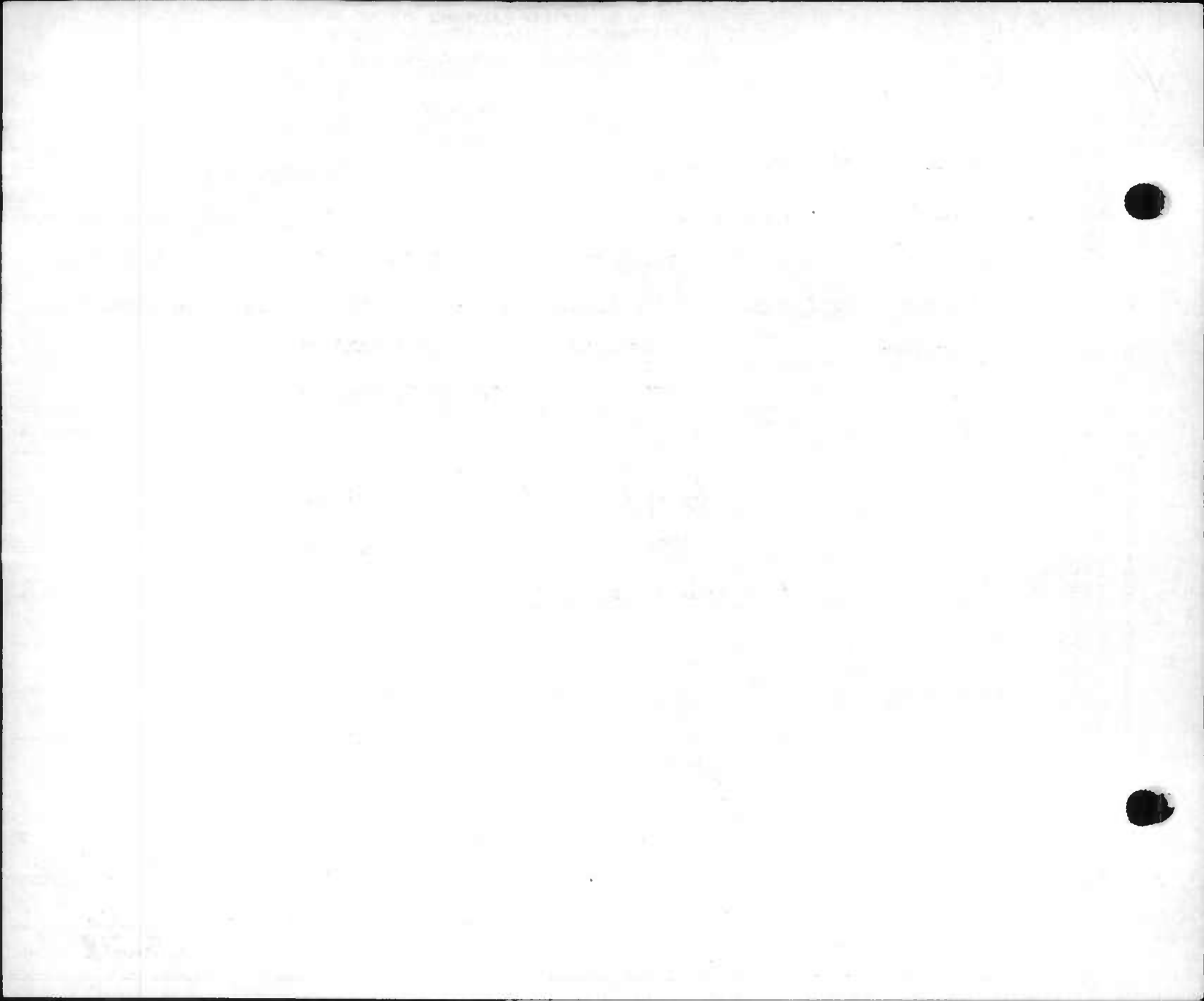
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

30812

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Goldie</b>		MIDDLE <b>NMN</b>		LAST <b>Shulman</b>		2a. DATE KNOWN OF ESTI DEATH MATED <input type="checkbox"/> MONTH DAY YEAR 19		2b. HOUR M	
3 SEX <b>Female</b>	4 RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 5, 1909</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD <b>11-19-83</b>	MONTH DAY YEAR	2d. HOUR <b>2:15</b> M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Poland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Gaithersburg</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>19906 Apple Ridge Place</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Benjamin Schwartz</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Not Ascertainable</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>577-58-8401</b>		17. INFORMANT <b>Robert R. Shulman</b>		ADDRESS <b>Same as No. 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <b>Lymphoblastic leukemia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Unlabeled</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Undisplaced Fracture Qh.p</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>Robert W. Palmer</b>		M.D.		MEDICAL EXAMINER <b>Cleared with Medical Examiner - Dr. Frank Mayle</b>		DATE SIGNED			
EXAMINER'S NAME (TYPE OR PRINT) <b>Robert W. Palmer</b>		ADDRESS <b>9715 Medical Center Drive</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/21/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King David Memorial Garden Falls Church, Virginia</b>		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Donald M. Stein</b>		HEBREW MEMORIAL F. <b>NOV 23 1983</b>		DATE REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <b>Sam J. Connel</b>			
222 Carroll Street, N. W. Washington, D. C.									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMM-16 30M 2/80  
(VRA 15, 4)1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30813

1. DECEASED NAME (TYPE OR PRINT) <b>Eleanor McK. Shumaker</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 10 83</b>			2b. HOUR <b>8<sup>20</sup> A.M.</b>			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Oct., 8, 1898</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carriage Hill Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5215 Cedar Lane 20815</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles McKnight</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eliza Cochran Wilson</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>577-24-5684</b>		17. INFORMANT ADDRESS <b>Margaret S. Nalle 1402 21st St. NW Washington, D.C. 20036 (Daughter)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>4/40</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b> <b>15 years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>77</b> , to <b>10 Nov</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>9 Nov</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) did not view the body after death.									
22b. SIGNATURE <b>Richard M. Huffman M.D.</b>				DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>10 Nov 83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Richard M. Huffman, M.D.</b>				22e. ADDRESS <b>3301 New Mexico Ave NW #350 Washington, D.C.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>10 Nov 83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>			
24. FUNERAL DIRECTOR NAME <b>J. William Lee's Sons Company</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1983</b>		25b. REGISTRAR'S SIGNATURE <b>J. W. Lee</b>			
300 4th St. NE Washington, D.C. 20002									

negative test failure

Ca vol nt

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 30814	
1. FOR STATE REGISTRAR					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HOWARD FRANCIS SHUMATE			2a. DATE OF DEATH MONTH DAY YEAR November 17, 1983		2b. HOUR 2:55pm
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 12/12/19	6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W VA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH Perry Point, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MACHINIST		12b. KIND OF BUSINESS OR INDUSTRY BABCOCK &
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY ALLEGANY 13c. CITY FROSTBURG			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST CROCKET SHUMATE			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LILLIE MAE BRYSON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) YES WW II		16b. SOCIAL SECURITY NO. 232-28-6643		17. INFORMANT ADDRESS MRS. HOWARD F. SHUMATE, 72 W. MAIN ST.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: 4151 IMMEDIATE CAUSE (a) Pulmonary emboli and cerebral infarct DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from October 5, 1982, to November 17, 1983, xxxxxxxx and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Roy W. Chesnut, Jr.		DEGREE M.D.		22c. DATE SIGNED 11-17-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROY W. CHESNUT, M.D.		22e. ADDRESS VAMC, Perry Point, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11/21/83		23c. NAME OF CEMETERY OR CREMATORY BEAVER MAUSOLEUM	
23d. LOCATION CITY OR TOWN BEAVER		COUNTY BEAVER		STATE PA.	
24. FUNERAL DIRECTOR Sowers Funeral Home, Frostburg, Md.		25a. DATE REC'D. BY REGISTRAR NOV 23 1983		25b. REGISTRAR'S SIGNATURE San J. Conner	

10-10-68

October 10, 1968

MEMORANDUM FOR THE DIRECTOR

FROM: SAC, NEW YORK

RE: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.		
1- STATE REGISTRAR							30815					
1. DECEASED NAME (TYPE OR PRINT) <b>Anna Marjorie Silverstein</b>							2a. DATE KNOWN OF DEATH <b>Nov 7 1983</b>		2b. HOUR <b>6:40</b>		2c. DATE PRONOUNCED DEAD <b>Nov 7 1983</b>	
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>Apr 19 11</b>		6. AGE (IN YEARS) <b>72</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Georgia</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery, MD.</b>		
10. CITY OR TOWN OF DEATH <b>Pt. Spg</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hosp</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Schools</b>		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>20904</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery-Silver Spring</b>		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>17234 New Hampshire Ave.,</b>				
14. FATHER'S NAME FIRST <b>Lyman</b> MIDDLE <b>Randall</b> LAST <b>Mattie</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Mattie</b> MIDDLE <b>Christian</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>523-46-2009</b>		17. INFORMANT ADDRESS <b>Ann Gray-Same as items #13</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Dis.</b> 4292 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) } DUE TO, OR AS A CONSEQUENCE OF (c) }												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>None</b>												
19a. DATE OF OPERATION <b>1-29-83</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>L. hip replacement</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE <b>John S. Rogers</b>				TITLE (SPECIFY) <b>M.D.</b>				DATE SIGNED <b>Nov 7 1983</b>				
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers</b>				ADDRESS <b>1919 Seminary Rd., S.S., Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>11/8/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood, P.G., Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Ed. Wallen</b> ADDRESS <b>254 Carroll St. NW</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 9 1983</b>				25b. REGISTRAR'S SIGNATURE <b>John J. Cariff</b>				
Takoma Funeral Home-Wash, D.C., 20012												

20000

100-100000

John Smith

100-100000



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Bessie Ms Simms</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-18-83</b>			2b. HOUR <b>4:23</b> M	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12-24-09</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>73</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Bowman, S.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Mont Co.</b> MD.	
10. CITY OR TOWN OF DEATH <b>Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Fed. Govt.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>D. C.</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Mack Henry Thompson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Edna Thompson</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>578-09-7415</b>	
17. INFORMANT <b>Ms. Edna E. Simms/daughter/10037 Campusway</b>		18. ADDRESS <b>Upper Marlboro, Md</b>		19. DATE OF OPERATION		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART 1. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Aspiration Pneumonia**  
DUE TO, OR AS A CONSEQUENCE OF (b) **coma**  
DUE TO, OR AS A CONSEQUENCE OF (c) **cerebrovascular Accident - new**  
Approximate interval between onset and death:  
**25 days**  
**39 days**  
**39 days**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  
**Old cerebrovascular Accident, Diabetes mellitus**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <b>July 12, 1983</b> to <b>November 16, 1983</b> , that (I) (we) last saw the deceased alive on <b>November 17, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <b>Don H. Yablonsky</b> DEGREE <b>MD</b>	
22c. DATE SIGNED <b>11/18/83</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Don H. Yablonsky, MD</b>		22e. ADDRESS <b>10300 Greenbelt Rd, Suite 101, Seabrook</b>		22f. DATE REC'D. BY REGISTRAR <b>NOV 22 1983</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-23-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>John T. Rhines Co.</b> ADDRESS <b>3015 12th St. N.E., D.C.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 22 1983</b>			

RECEIVED  
JAN 10 1964  
FBI - NEW YORK



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH				MONTH		DAY		YEAR		2b. HOUR	
Samuel H Sklaroff								11-10-83										7:09 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		(IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS							
Male		White		11 24 91		91		YRS.		MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
Russia		USA		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery MD.													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Silver Spring		Holy Cross Hospital		Food Specialist		Food Industry													
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		Montgomery		Chevy Chase		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				3221 Brooklawn Terrace (20815)									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
Tzvi		Zippora																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
No		437-01-0347		Claire Marwick; 3221 Brooklawn Terrace; Chevy Chase, Md. 20815															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1890 Metastatic carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) Clear cell carcinoma right kidney DUE TO, OR AS A CONSEQUENCE OF (c) 134rs																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that (I) (this hospital) attended the deceased from JAN 5, 19 83, to Nov 10, 19 83, that (I) (we) lost saw the deceased alive on Nov 9, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Hubert J. Alpert MD		22c. DATE SIGNED 10 Nov 83															
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS																	
HUBERT J. ALPERT, MD		8630 FENTON ST. SILVER SPRING, MD 20910																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE													
Burial		Nov. 11, 83		Beth Shalom Cong. Cemetery; Capital Heights; P.G.; Md.															
24. FUNERAL DIRECTOR		24b. DATE REC'D. BY REGISTRAR		24c. REGISTRAR'S SIGNATURE															
DANZANSKY-GOLDBERG MEMORIAL CHAPELS		NOV 1-4 1983		John J. Connel															
1170 Rockville Pike; Rockville, Maryland 20852																			

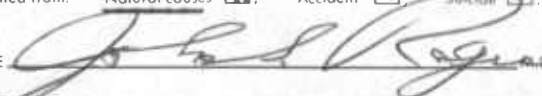
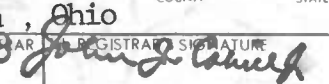
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OFFICE OF THE  
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BUREAU OF THE  
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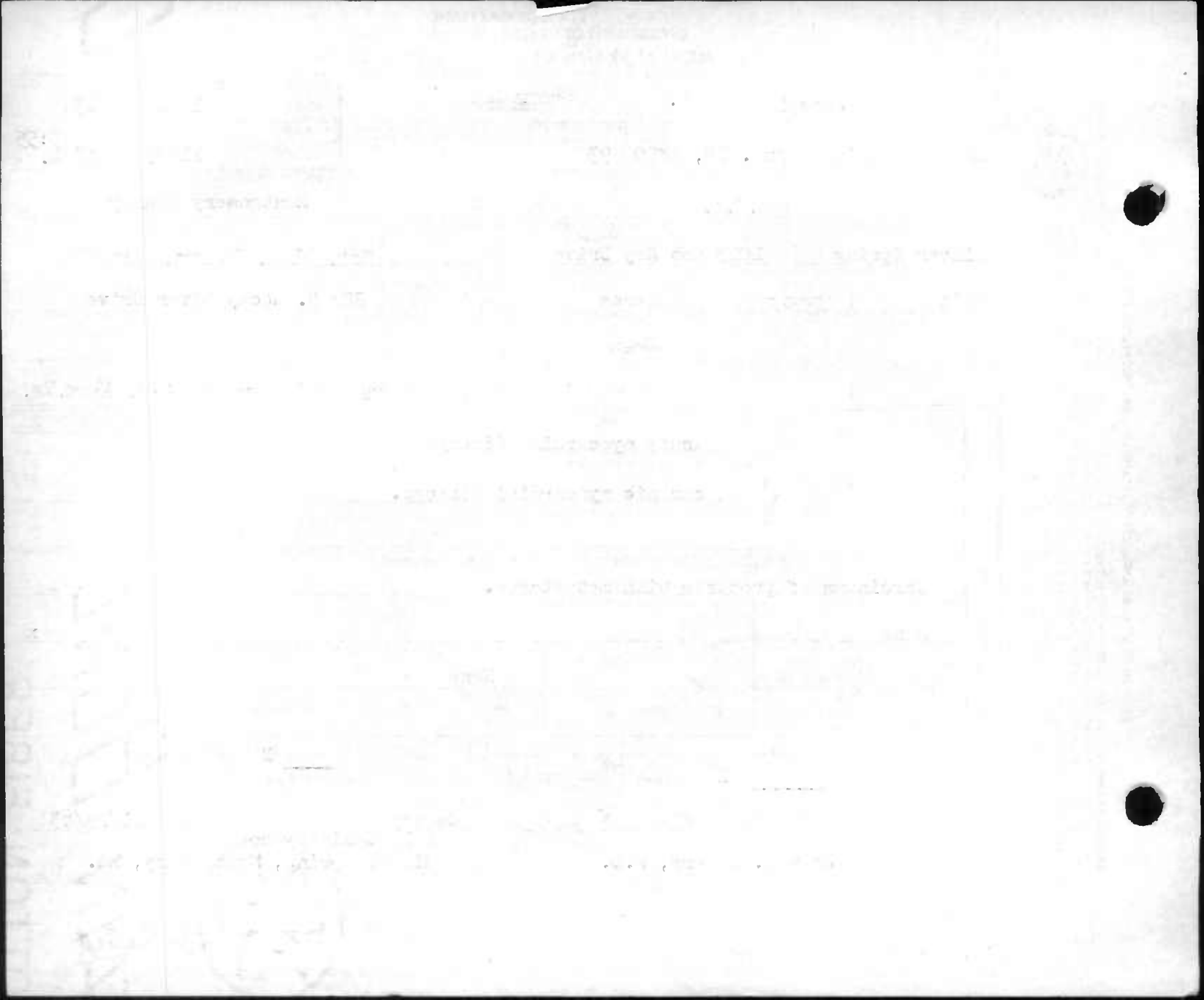


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CENSUS

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Joseph F. Skora</b>										2a. DATE KNOWN OF DEATH ESTI-MATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11/29 83</b>		2b. HOUR <b>5:55 A.</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 19, 1890</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>93</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>11/29 83</b>		24. HOUR <b>5:55 A.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b>	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1013 Rob Roy Drive</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Bldg. Contra.</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Housing</b>	
13a. STATE <b>Ohio</b>				13b. COUNTY <b>Cuyhoga</b>		13c. CITY OR TOWN <b>Berea</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>228 N. Rocky River Drive</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Skora</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Rozanski</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>297-30-4516</b>				17. INFORMANT ADDRESS <b>Eugene Skora 5 Washington Cir. Alex. Va.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4291</b> IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>chronic myocardial disease.</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>Carcinoma of prostate with metastases.</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>None</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE 				TITLE (SPECIFY) <b>Deputy</b>				MEDICAL EXAMINER <b>1919 Seminary Road</b>				DATE SIGNED <b>11/29/83</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>				ADDRESS <b>Silver Spring, Montgomery, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>12-1-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Adalberts Cem</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Berea, Ohio</b>			
24. FUNERAL DIRECTOR NAME <b>Everly-Wheatley Funeral Home, Alexandria, Va.</b>						25. REGISTERED PROFESSIONAL REGISTRAR SIGNATURE 							





BH

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 8 1 9

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR				
FIRST	MIDDLE	LAST	MONTH	DAY	YEAR	MONTH	DAY	YEAR		
CRAIG WILLIAM SMITH			NOVEMBER 21, 1983			6:12 <sup>A</sup> M				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		
MALE		WHITE		MONTH DAY YEAR		32 YRS		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Conn.		USA				MONTGOMERY COUNTY MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA			THE CLINICAL CENTER, NIH			Ballet Dancer			Private Ind.	
13a. STATE			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
VIRGINIA			CHARLOTTES-		YES <input type="checkbox"/> NO <input type="checkbox"/>		1816 YORKTOWN DR (22901)			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			ADDRESS				
FIRST MIDDLE LAST			FIRST MIDDLE LAST							
Harold Smith			Dorothy Smith							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT				
no			041-46-3200			LOUISE SMITH (WIFE) SAME AS ABOVE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u>								4 hours		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								3 days		
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute hydrocephalus</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Intracranial mass</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
			P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (x) this hospital attended the deceased from <u>July 7, 1983</u> to <u>November 21, 1983</u> , that (x) we last saw the deceased alive on <u>November 21, 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) we (did) (did not) view the body after death.										
22b. SIGNATURE DEGREE						22c. DATE SIGNED				
<u>Jay E. Slater MD</u>						11/21/83				
22e. PHYSICIAN'S NAME (TYPE OR PRINT)						22d. ADDRESS				
JAY E. SLATER MD						NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MARYLAND 20205				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
CREMATION			11-22-83		Lee's Crematory		Washington, D.C.			
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Marshall's Funeral Home 4217 9th St NW: Washington, D.C.						NOV 28 1983		<u>John J. Carver</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. FOR STATE REGISTRAR				3 0 8 2 0	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>FRANCIS JOSEPH SMITH</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 24 1983</b>		2b. HOUR <b>6:18 P<sub>M</sub></b>
3. SEX <b>MALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>APRIL 29 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.		10. CITY OR TOWN OF DEATH <b>BETHESDA</b>	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S.A.</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>PRINCE GEORGE'S</b>		13c. CITY OR TOWN <b>HYATTSVILLE</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>CHARLES SMITH</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>DELIA MURPHY</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>	
17. INFORMANT <b>ADELAIDE W. SMITH</b>		18. SOCIAL SECURITY NO. <b>097-07-9360</b>		19. ADDRESS <b>7400 17th Avenue</b>	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>OVERWHELMING SEPSIS</b>		21. HYATTSVILLE, MD 20783		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
22. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		23. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause lost.		24. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)	
25. DATE OF OPERATION <b>NOVEMBER 8 1983</b>		26. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>OVERWHELMING SEPSIS</b>		27. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
28. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
31. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		32. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		33. LOCATION STREET CITY OR TOWN COUNTY STATE	
34. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 8 1983</b> , to <b>NOVEMBER 24 1983</b> , that (I) (we) lost saw the deceased alive on <b>NOVEMBER 24 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		35. SIGNATURE <b>Wm. L. Shankel</b>		36. DEGREE <b>MD</b>	
37. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W. SHANKEL, CDR, MC, USNR</b>		38. ADDRESS <b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>		39. DATE SIGNED <b>25 Nov 83</b>	
40. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		41. DATE <b>Nov. 29 1983</b>		42. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>	
43. FUNERAL DIRECTOR NAME <b>Taking Funeral Home</b>		44. ADDRESS <b>254 Canal St. N.W. D.C.</b>		45. DATE REC'D. BY REGISTRAR <b>NOV 28 1983</b>	
46. REGISTRAR'S SIGNATURE <b>John J. Conner</b>		47. COUNTY <b>Ar</b>		48. STATE <b>Va</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such event.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTER

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Virginia Stover Smith</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Nov 6 83</i>		2b. HOUR <i>3:00 A M</i>
3. SEX <i>Female</i>	4. RACE <i>Caucasian</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>8-28-1904</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>79</i>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>15100 Glade Dr Silver Spring</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Writer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Newspaper</i>
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Silver Spring</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <i>William Ruffner Stover</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Martine Lockett</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>110-03-0342-8</i>		17. INFORMANT ADDRESS <i>Mary Shelly (sister) Same as above</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>3419</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Orthostasis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <i>Dehydrating disease</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>yes.</i> <i>yes.</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Severe osteoporosis</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov 1</i> 19 <i>82</i> to <i>Nov 6</i> 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>Nov 3</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Richard P. Delaney, MD</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>11/6/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>RICHARD P. DELANEY, MD</i>		22e. ADDRESS <i>4323 HARVARD ST. SIL. SPR. 20906</i>			

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>Nov. 8, 1983</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mountain View</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Bristol Washington Virginia</i>
24. FUNERAL DIRECTOR NAME <i>Francis J. Collins</i>		25a. DATE REC'D. BY REGISTRAR <i>NOV 14 1983</i>	25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>
500 University Blvd., W. Silver Spring, Md.			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Evelyn S. Snow</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>November 27, 1983</b>		2b. HOUR MIN. <b>1:30 pm</b>	
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>April 11, 1891</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wisconsin</b>	7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Fernwood House Retirement Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Lawyer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Internal Revenue Service</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Bethesda</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Andrew A. Smith</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Caroline Gertrude Olson</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	
16b. SOCIAL SECURITY NO. <b>579-58-0520</b>		17. INFORMANT (Niece) <b>Lois W. Collinge</b>		ADDRESS <b>9219 Shelton Street Bethesda, Maryland 20814</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>4149</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>ventricular fibrillation</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>atherosclerotic coronary vascular disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>10 years</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Hypertension and chronic organic brain syndrome</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>80</b> , to <b>November 17</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>October 21, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>David V. Young</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>20008</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>David V. Young M.D.</b>		22e. ADDRESS <b>4530 Connecticut Avenue, NW, Washington, D.C.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec. 2, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Church Cemetery Norway Hill Lutheran</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Waterford Wisconsin</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Robert A. Pumphrey Funeral Homes, P.A., 7557 Wisconsin Avenue, Bethesda, MD</b>			
25a. DATE REC'D. BY REGISTRAR <b>DEC 2 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. C...</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18, immediately injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30823

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>max Sokolowsky</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>11/12/83</i>			2b. HOUR <i>12<sup>15</sup> AM</i>			
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>3 31 95</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>88</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) (TRY) <i>RUSSIA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.			
10. CITY OR TOWN OF DEATH <i>SILVER SPRING</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>TRINITY CROSS HOSPITAL</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Merchant</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Shoes</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <i>Maryland Prince Georges Beltsville</i>				13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE <i>11433 Cherry Hill Road, #202 20705</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Sam Sokolowsky</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Rachel Lubchansky</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>087-28-3290</i>		17. INFORMANT <i>1010 Robroy Drive Mrs. Gilda Kuritzky Silver Spring, Maryland</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>4340</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)									
19a. DATE OF OPERATION <i>10/19</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>10/19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from <i>10/19</i> 19 <i>83</i> to <i>11/12</i> 19 <i>83</i> , that (I) <del>last</del> saw the deceased alive on <i>11/11</i> 19 <i>83</i> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>we</del> (did) (did not) view the body after death.									
22b. SIGNATURE <i>Norman H. Rubenstein</i>				DEGREE <i>MD</i>				22c. DATE SIGNED <i>11/12/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>11/13/1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Judean Memorial Gardens</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Olney, Montgomery, Maryland</i>			
24. FUNERAL DIRECTOR <i>Donald M. Stein Hebrew Memorial F.H. 232 Carroll Street, N. W. Washington, D. C.</i>				25a. DATE REC'D. BY REGISTRAR <i>NOV 16 1983</i>					

BOOK

FILE

NOV 18 1938  
Randy Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30824

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CLARA W. SOLOMON			2a. DATE OF DEATH MONTH DAY YEAR 11 3 83			2b. HOUR 4 25 A.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 14, 1888		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery, MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hebrew Home of Greater Washington				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. STREET ADDRESS 6121 Montrose Road (20852)		
14. FATHER'S NAME FIRST MIDDLE LAST JULIUS WOLF			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EVA (UNKNOWN)			16. ADDRESS 20783			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-42-9242		17. INFORMANT Helen Lerner; 2123 Ruatan Street; Adelphi, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 YEARS 20 YEARS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Senile Dementia</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11/3</u> <u>12/24</u> <u>1983</u> to <u>4/3</u> <u>1983</u> , that (I) (we) lost saw the deceased alive on <u>11/3</u> <u>1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Robert L. Rosenberg</u>			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 11/3/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT L. ROSENBERG, MD			22e. ADDRESS 1131 UNIVERSITY BLVD W, SILVER SPRING, MD 20902						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/4/83		23c. NAME OF CEMETERY OR CREMATORY Adas Israel Cong. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.		
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Maryland 20852			25a. DATE REC'D. BY REGISTRAR NOV 7 1983			25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>			



Printed by the Government of India at the Government Press, Calcutta.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 8 2 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>KENNETH ALEXANDER SOLOMON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 26 1983</b>		2b. HOUR <b>9:05 a</b> M		
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>NOVEMBER 13 1961</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>22</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MICHIGAN</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>U. S. NAVY</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>OHIO</b>		13b. COUNTY <b>WAYNE</b>		13c. CITY OR TOWN <b>ORRVILLE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>P. O. BOX 346</b>		13f. STREET ADDRESS <b>99999</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>ELIJAH SOLOMON</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BERTHA CORINE GILLERY</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1981-1983</b>		17. INFORMANT ADDRESS <b>BERTHA C. BONNER, 19233 ST. AUBIN, DETROIT, MI</b>			

8 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

2791

IMMEDIATE CAUSE (a) **ACQUIRED IMMUNE DEFICIENCY SYNDROME**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 12, 1983</b> , to <b>NOVEMBER 26, 1983</b> , that (I) (we) last saw the deceased alive on <b>November 26, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED

28 NOV 83

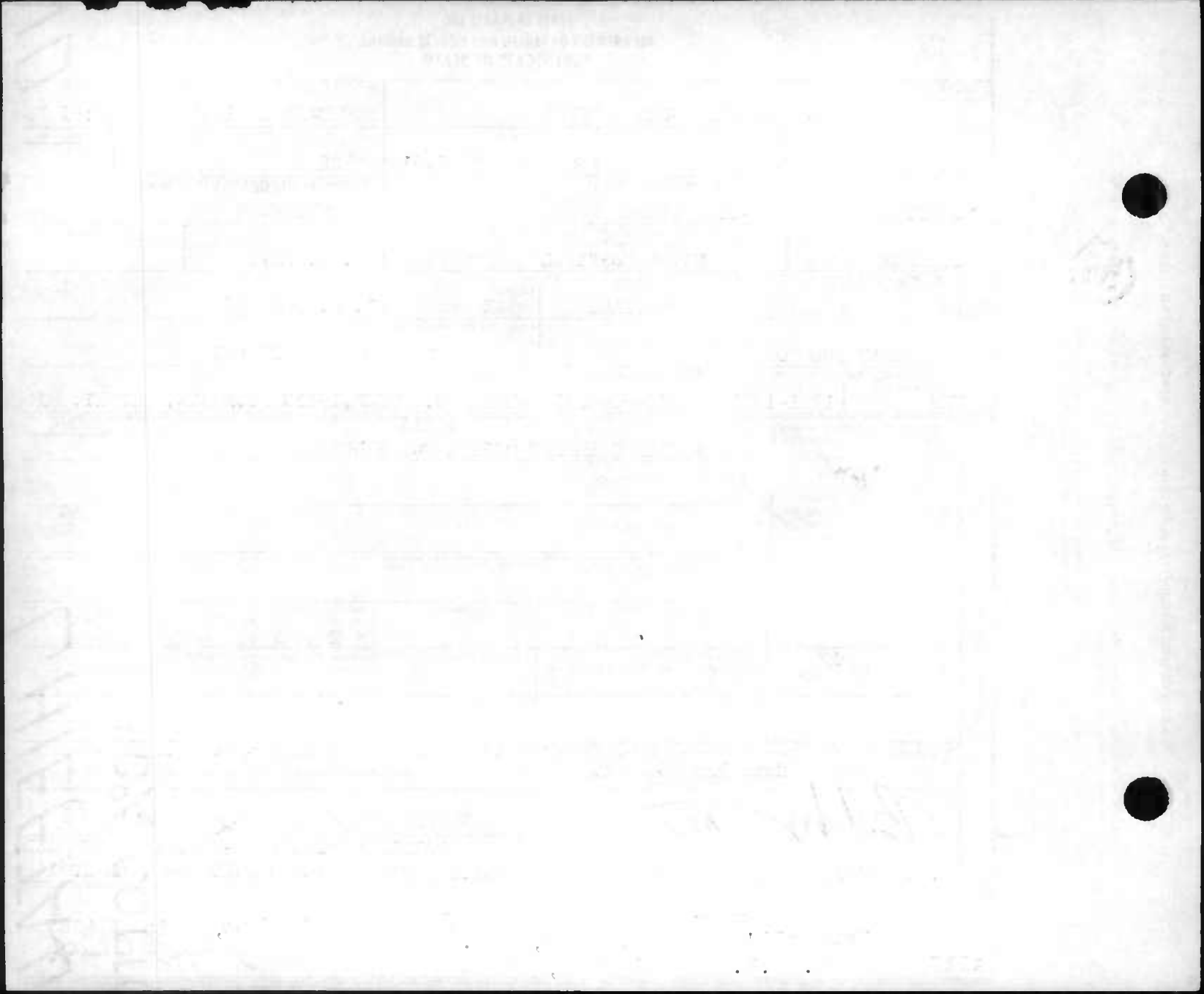
22d. PHYSICIAN'S NAME (TYPE OR PRINT)

**B. CHERNOW, LCDR, MC, USN**

22e. ADDRESS

**NAVAL HOSPITAL, NAVAL MEDICAL COMMAND,  
NATIONAL CAPITAL REGION, BETHESDA, MD 20814**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>11-30-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Auble Funeral Home</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Orrville Ohio 44667</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Marshall's Funeral Home, Inc. 4217 9th St. N.W. Washington, DC</b>				25a. DATE REC'D BY REGISTRAR <b>DEC 5 1983</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Carter</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 8 2 6

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST <b>Lettie Hazel Souder</b>		MONTH DAY YEAR <b>Nov. 9 1883</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>	
5. DATE OF BIRTH MONTH DAY YEAR <b>May 28 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Rockville Nursing Home</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret'd Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>	
13c. CITY OR TOWN <b>Gaithersburg</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>13 Cedar Avenue</b>		13f. STREET ADDRESS <b>20877</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William H. Souder</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Pamma B. Faulk</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>219-36-8328</b>	
17. INFORMANT <b>Richard S. Barnsley</b>		ADDRESS <b>7407 Gatewood Ct. Alexandria, Va. 22307</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Osteoporosis, Peripheral neuropathy, Hypertension</b>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21c. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21d. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) this hospital attended the deceased from <b>Nov 23</b> , 19 <b>83</b> , to <b>Nov 9</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>Nov 7</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>James R. Moore Jr.</b>		DEGREE <b>MD</b>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT)		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. ADDRESS <b>207 Brookes Ave Gaithersburg</b>		22e. DATE SIGNED <b>11-9-83</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/12/83</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Gaithersburg Montgomery Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Gartner Sandison F.H.</b>		25a. BY <b>14883</b> 25b. REASON FOR SIGNATURE	
ADDRESS <b>316 E. Diamond Ave. Gaithersburg, Md. 20877</b>			

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JAN 1 1960





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BP \_\_\_\_\_

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30827

1 - FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) ESTELLE V. SPAULDING		2a. DATE OF DEATH MONTH DAY YEAR 11 10 83	
3. SEX Female		2b. HOUR 308 PM	
4. RACE White		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
5. DATE OF BIRTH MONTH DAY YEAR May 17, 1902		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MI		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR INDUSTRY Banking	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD 20817		13b. COUNTY Montgomery	
13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 7401 Westlake Terr. #707		14. FATHER'S NAME FIRST MIDDLE LAST Otto M. Ulrich	
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Olga Popp		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 368-18-3025		17. INFORMANT ADDRESS Potomac, MD 20854 Richard L. Spaulding 10826 Hob Nail Court	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac standstill (asystole)</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ischemic cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary heart disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 mins	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>NOV 4</u> , 19 <u>83</u> , to <u>NOV 10</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>NOV. 10</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Thomas H. Sindereson, M.D.		22c. DATE SIGNED 11-10-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS G. SINDERESON, M.D.		22e. ADDRESS 11125 ROCKVILLE AVE, ROCKVILLE, Md. 20852	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial-Removal		23b. DATE 11/11/83	
23c. NAME OF CEMETERY OR CREMATORY Balcom Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Ionia, MI	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. NAME 5130 Wisc. Ave. N.W. ADDRESS Wash., DC 20016		25a. DATE REC'D. BY REGISTRAR NOV 16 1983	
25b. REGISTRAR'S SIGNATURE			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 8 2 8

1. FOR  
STATE  
REGISTRAR

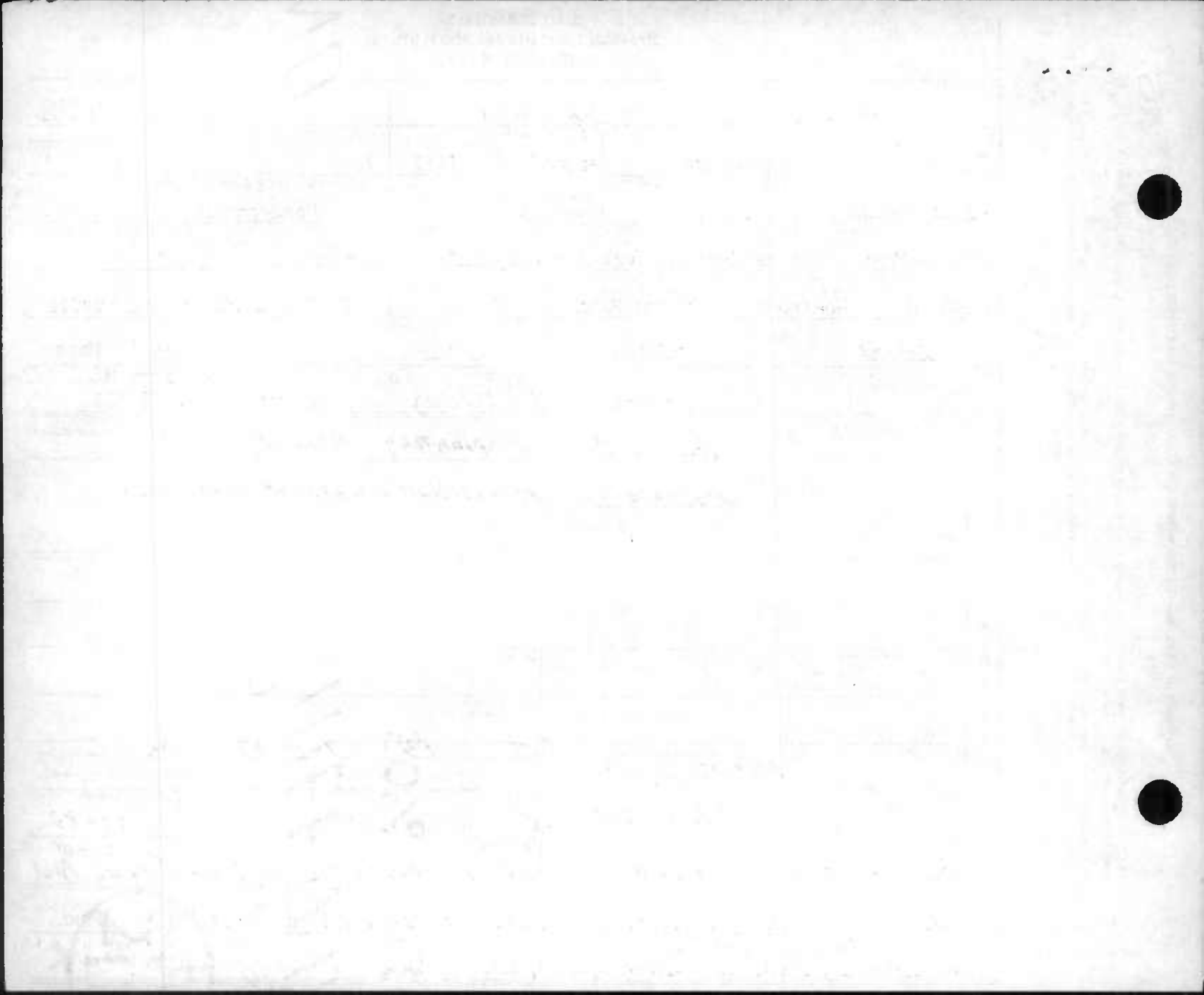
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Marie D. Spicher</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Nov. 27 '83</i>		2b. HOUR <i>11:30 AM</i>		
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>August 16 1907</i>		6. AGE (IN YEARS (LAST BIRTHDAY)) YRS. MONTHS DAYS HOURS MIN. <i>76</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Takoma Park</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Richard Diller</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Nellie Myer Meyer</i>		16. STREET ADDRESS <i>7051 Carroll Avenue 20912</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>		16b. SOCIAL SECURITY NO. <i>174-42-0565</i>		17. INFORMANT <i>Richard Tom Spicher</i>		ADDRESS <i>4634 Aspen Hill Rd. Rockville, Md. 20853</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardio-Respiratory Arrest</i> 4029 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertensive-Arteriosclerotic Cardiovascular Dis.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <i>OCT 1983</i> to <i>Nov 27 1983</i> that (I) (we) lost saw the deceased alive on <i>Nov 27 1983</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Bernard A. Fitzgerald MD</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11-27-83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>BERNARD A. FITZGERALD</i>				22e. ADDRESS <i>217 UNIVERSITY BLVD E, SILVER SPRING MD 20901</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Nov. 30, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Brackenridge Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Rockville Montgomery Penn.</i>	
24. FUNERAL DIRECTOR NAME <i>Francis J. Collins</i>				25a. DATE REC'D. BY REGISTRAR <i>DEC 2 1983</i>			
500 University Blvd., W. Silver Spring, Md.				25b. REGISTRAR'S SIGNATURE <i>John J. Casper</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical officer should be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 3 0 8 2 9 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME FIRST <b>PERRY</b> MIDDLE <b>JOHN</b> LAST <b>SPYROPOULOS</b> <i>Perry John SPYROPOULOS</i>										2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY <b>11</b> YEAR <b>1983</b>		2b. HOUR OF DEATH <b>11:15 AM</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>09</b> DAY <b>22</b> YEAR <b>62</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>21</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH <b>11</b> DAY <b>18</b> YEAR <b>1983</b>		2d. HOUR <b>11 AM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON, D.C.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>America</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Bethesda, MD</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>STUDENT</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>COLLEGE</b>			
13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>MONTG.</b>		13c. CITY OR TOWN <b>BETHESDA</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>9415 LINDEN AVE. 20814</b>			
14. FATHER'S NAME FIRST <b>CONSTANTINE</b> MIDDLE LAST <b>SPYROPOULOS</b>				15. MOTHER'S MAIDEN NAME FIRST <b>ALICE</b> MIDDLE LAST <b>KATSAPIS</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>578-84-9873</b>		17. INFORMANT ADDRESS <b>CONSTANTINE SPYROPOULOS 9415 LINDEN AVE. BETHESDA, MD.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: <b>8199</b> IMMEDIATE CAUSE (a) <b>Cerebral Compression Syndrome</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Severe Cerebral Trauma</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR <b>11</b> A.M. MONTH <b>11</b> DAY <b>15</b> YEAR <b>1983</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) <b>Single Car accident</b>							
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Street</b>		21f. LOCATION STREET <b>Burdette and Heathwood</b> CITY OR TOWN <b>Bethesda</b> COUNTY <b>MD.</b> STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>John Tauber</i>				TITLE (SPECIFY) <b>M.D.</b>				MEDICAL EXAMINER <b>Bethesda MD</b>				DATE SIGNED <b>11-18-83</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>John Tauber</b>				ADDRESS <b>8218 WISCONSIN AVE</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>11-21-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEME.</b>				23d. LOCATION CITY OR TOWN <b>BLADENSBURG</b> COUNTY <b>P.G.</b> STATE <b>MD.</b>			
24. FUNERAL DIRECTOR NAME <b>JOS. GAWLERS' SONS</b>						ADDRESS <b>5130 WISC. AVE. NW. WASH., D.C.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 23 1983</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30830

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Vera C Stant			2a. DATE OF DEATH MONTH DAY YEAR 11/22/83		2b. HOUR 2:4 A.M.
3. SEX FEMALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 8 5 1927		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Editor		12b. KIND OF BUSINESS OR INDUSTRY U.S. Dept. Agriculture
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Kensington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 3511 Kent Street 20895
14. FATHER'S NAME FIRST MIDDLE LAST Albert Chiera		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elena			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-30-2445		17. INFORMANT ADDRESS Robert E. Stant Husband Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>bleeding cerebral aneurysm</u> 7531 DUE TO, OR AS A CONSEQUENCE OF (b) <u>polycystic kidney disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 30 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 21</u> 19 <u>83</u> , to <u>Nov 22</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>Nov 21</u> 19 <u>83</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Charles Roun		DEGREE MD		22c. DATE SIGNED 11/22/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark S. Rosen, MD		22e. ADDRESS Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 26, 1983		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D. C.		24. FUNERAL DIRECTOR NAME Francis J. Collins ADDRESS 500 University Blvd., W. Silver Spring, MD.			
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE DEC 2 1983 John J. Lohr			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requiring that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and is duly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST John Robert Stapleton			MONTH DAY YEAR 11 14 83			5:17a M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Male	Caucasian	MONTH DAY YEAR 12 04 12	70 years			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
New York	U.S.A.		Montgomery County MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring	Holy Cross Hospital		Data Analyst			Security Assoc.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. INSIDE CITY LIMITS?			13c. STREET ADDRESS		
13a. STATE COUNTY CITY OR TOWN Maryland Montgomery Silver Spring			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			10304 Edgewood Avenue 20901		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Richard Stapleton			Margaret Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT		
Yes WWII			104-10-7136			Grace M. Stapleton Wife Same as 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Cardipulmonary Arrest								minutes
4292 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis Cardiovascular Disease								years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)								
Diabetes Mellitus								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from			19 48 to November 14, 19 83, that (I) xx lost					
saw the deceased alive on			October 20, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE			DEGREE			22c. DATE SIGNED		
DeW. H. E. DeLauter			M.D.			11-14-83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
DeW. H. E. DeLauter			6318 Democracy Blvd; Bethesda, MD 20817					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial			Nov. 17, 1983		Gate of Heaven		Silver Spring Mont. Md.	
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Francis J. Collins			NOV 21 1983			John J. Conner		
500 University Blvd., W. Silver Spring, Md.								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

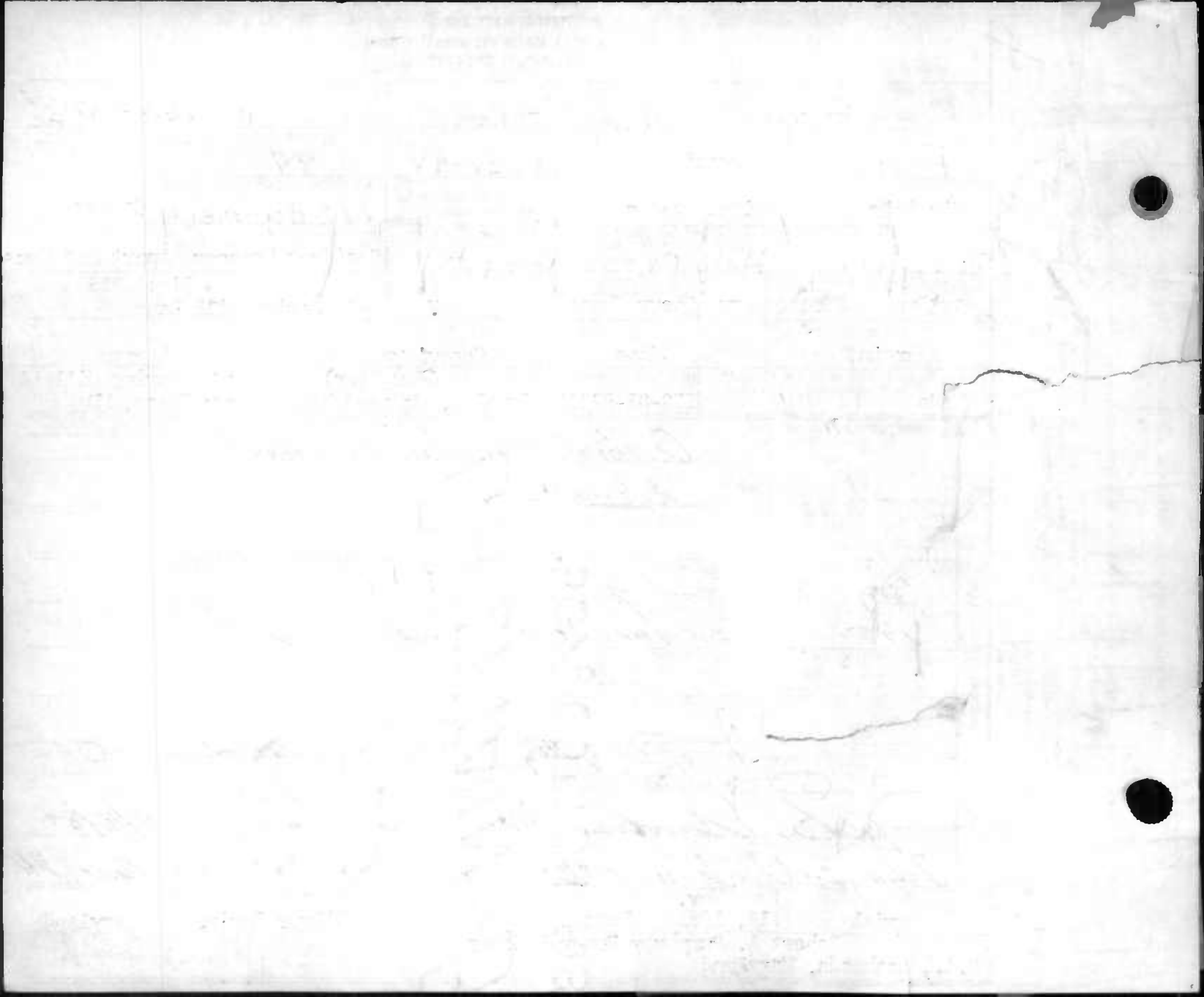
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Genevieve A Stokes</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-16-83</b>			2b. HOUR <b>12:55 AM</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12-28-98</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD</b>			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Resident Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Apartment House</b>		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Chevy Chase</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>9005 Spring Hill Lane,</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ephraim Adams</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Genevieve Lannon</b>		16. SOCIAL SECURITY NO. <b>578-01-9948A</b>					
17. INFORMANT (Daughter) <b>Jewel R. McDonough</b>		ADDRESS <b>9005 Spring Hill LA Chevy Chase, MD</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular accident</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>7</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Congestive heart failure.</b>									
19a. DATE OF OPERATION <b>1982</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma of R.D. Breast</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>11/15/83</b> to <b>11/16/83</b> , that (I) (we) last saw the deceased alive on <b>11/15/83</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Dr. B. Umhauer</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/16/83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John B. Umhauer MD</b>		22e. ADDRESS <b>8805 Conn. Ave. Chevy Chase, Md</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 18, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 17 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Lohr</b>			

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STATE OF MARYLAND 8 3 3 0 8 3 3  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Blanche F. Stottlemeyer			2a. DATE OF DEATH MONTH DAY YEAR 11 14 83			2b. HOUR 12:02 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR December 20, 1884		6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.			
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Herman Wilson Health Care Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Saleslady		12b. KIND OF BUSINESS OR INDUSTRY Dry Goods Store			
13a. STATE Maryland		13b. COUNTY P.G. Co.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5617 31st Avenue (20782)	
14. FATHER'S NAME FIRST MIDDLE LAST John Halsey Foltz		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma L. Spindler		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No None					
16b. SOCIAL SECURITY NO. 577-12-0870		17. INFORMANT ADDRESS Dorothy LoPiccolo 5617 31st Ave. Hyattsville, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular arrhythmia</u> 4960 DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic obstructive pulmonary disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>78</u> , to <u>1/14</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>11/10</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John R. Melnick MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/14/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Melnick MD		22e. ADDRESS 16220 Frederick Rd. Gaithersburg Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov/17/83		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G. Co., Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Chambers Funeral Home Riverdale, Maryland				25a. DATE REC'D. BY REGISTRAR NOV 17 1983		25b. REGISTRAR'S SIGNATURE John J. Conner			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon-part. Pages 1 and 2 should be filed within 10 days of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is not any injury, or other traumatic event, the medical examiner must be notified.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										30834	
FOR REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>George G. Sward</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>11</b> DAY <b>12</b> YEAR <b>83</b>		2b. HOUR <b>8:00</b> PM			
1. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		3. DATE OF BIRTH MONTH <b>4</b> DAY <b>8</b> YEAR <b>92</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>91</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD <b>11 12 83</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Iowa</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery Co., MD.</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Paint Assoc.</b>		
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Chemist</b>					
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Chevy Chase</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2825 Greenvale Street 20815</b>		
14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b>Sward</b> LAST <b>Sward</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Anna</b> MIDDLE <b>Carlson</b> LAST <b>Carlson</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>578 07 6592</b>		17. INFORMANT ADDRESS <b>Frances S. Sward Wife Same as 13e</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>8880</b> IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>atherosclerotic heart</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Disease</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Fractured left hip with prosthetic replacement</b>											
19a. DATE OF OPERATION <b>10-30 83</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Fractured hip</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR <b>3:30</b> MONTH <b>10</b> DAY <b>29</b> YEAR <b>83</b> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Fell on Pavement</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Street</b>		21f. LOCATION STREET <b>Safeway store arlington Rd.</b> CITY OR TOWN <b>Bethesda</b> COUNTY <b>Montgomery</b> STATE <b>MD</b>					
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>John Tauber</b>				TITLE (SPECIFY) _____ M.D. _____				MEDICAL EXAMINER DATE SIGNED <b>11-12-83</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>John Tauber</b>				ADDRESS <b>8218 Wisconsin Ave</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Nov. 13, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory</b>				23d. LOCATION CITY OR TOWN <b>Alexandria</b> COUNTY <b>Virginia</b> STATE <b>Virginia</b>			
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John G. Carver</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local health officer.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 8 3 5

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Albert G Sweetman</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-9-83</b>			2b. HOUR <b>1:05</b> M			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 06 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b>		7. UNDER 1 YEAR MONTHS DAYS <b>XXXXXX</b>	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		9b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Truck Mechanic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Private Ind.</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Sweetman</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Laura Horn</b>			13e. STREET ADDRESS / ZIP CODE <b>2305 Greenery Lane T-3</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>WWI</b>		17. INFORMANT ADDRESS <b>Albert J. Sweetman Son Same as 13</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>4149</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 78</b> to <b>Present</b> 19 <b>83</b> , that (I) (we) lost <b>Nov 8</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22a. SIGNATURE <b>John Merendino</b>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>11/9/83</b>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS <b>11620 Kempmill Rd, Silver Spring Md. 20902</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Nov. 12, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Mont. Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b> ADDRESS <b>500 University Blvd., W. Silver Spring, Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>NOV 17 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John G. Chief</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HELEN F. O'Donnell SWEENEY</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 20/83</b>		2b. HOUR MIN. <b>5:40</b>		M	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>02 29 04</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>79</b>		IF UNDER 1 YEAR MONTHS DAYS <b>79</b>		IF UNDER 24 HRS HOURS MIN. <b>5:40</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10. CITY OR TOWN OF DEATH <b>MARYLAND</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Randolph Hills Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>						13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Wheaton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Michael J O'DONNELL</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>HELEN DAY</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>210-36-3827</b>		17. INFORMANT ADDRESS <b>Mary H. Flood Daughter Same as 13</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>None</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Quete CVA June 1982</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Rockville MD 20852</b>							
22a. I certify that (I) (this hospital) attended the deceased from <b>June 25, 1982</b> , to <b>Nov 20, 1983</b> , that (I) (we) lost saw the deceased alive on <b>Nov 18, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Robert T. Thibadeau</b>						22c. DATE SIGNED <b>11-20-83</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT T. THIBADEAU</b>						22e. ADDRESS <b>ROCKVILLE, MD 20852</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 25, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pittsburgh Allegheny Pa.</b>					
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 25 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>			
500 University Blvd., W. Silver Spring, Md.											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR STATE REGISTRAR

1. DECEASED NAME FIRST MIDDLE LAST  
**MARSHALL ARCHIBALD SYKES**

2a. DATE OF DEATH MONTH DAY YEAR  
**NOVEMBER 23 1983**

2b. HOUR  
**1:20 P.M.**

3. SEX  
**MALE**

4. RACE  
**CAUCASIAN**

5. DATE OF BIRTH MONTH DAY YEAR  
**JUNE 12 1915**

6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS  
**68**

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
**WASHINGTON, DC**

7b. CITIZEN OF WHAT COUNTRY?  
**UNITED STATES**

8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH  
**MONTGOMERY MD.**

10. CITY OR TOWN OF DEATH  
**BETHESDA**

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
**NAVAL HOSPITAL**

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
**RETIRED**

12b. KIND OF BUSINESS OR INDUSTRY  
**U.S.M.C.**

13a. STATE  
**MARYLAND**

13b. COUNTY  
**PRINCE GEO'S**

13c. CITY OR TOWN  
**BLADENSBURG**

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS  
**4406 53RD Place 20710**

14. FATHER'S NAME FIRST MIDDLE LAST  
**WILLIAM ARCHIBALD SYKES**

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
**BERTHA OZELLA NORTON**

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  
**YES**

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)  
**1931-1962 577-03-7504**

17. INFORMANT ADDRESS  
**Mr. Thornton S. Sykes Dunkirk, Md. 293 Fairhaven Rd.**

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **METASTATIC CARCINOMA**  
DUE TO, OR AS A CONSEQUENCE OF (b) **1991**  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
**19**

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from **OCTOBER 30 1983**, to **NOVEMBER 23 1983**, that (I) (we) last saw the deceased alive on **NOVEMBER 23 1983**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE  
**F. Hixon M.D.**

22c. DATE SIGNED  
**25 Nov. 83**

22d. PHYSICIAN'S NAME (TYPE OR PRINT)  
**F. HIXON, LT, MC, USNR**

22e. ADDRESS  
**NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  
**Burial**

23b. DATE  
**Nov. 29, 1983**

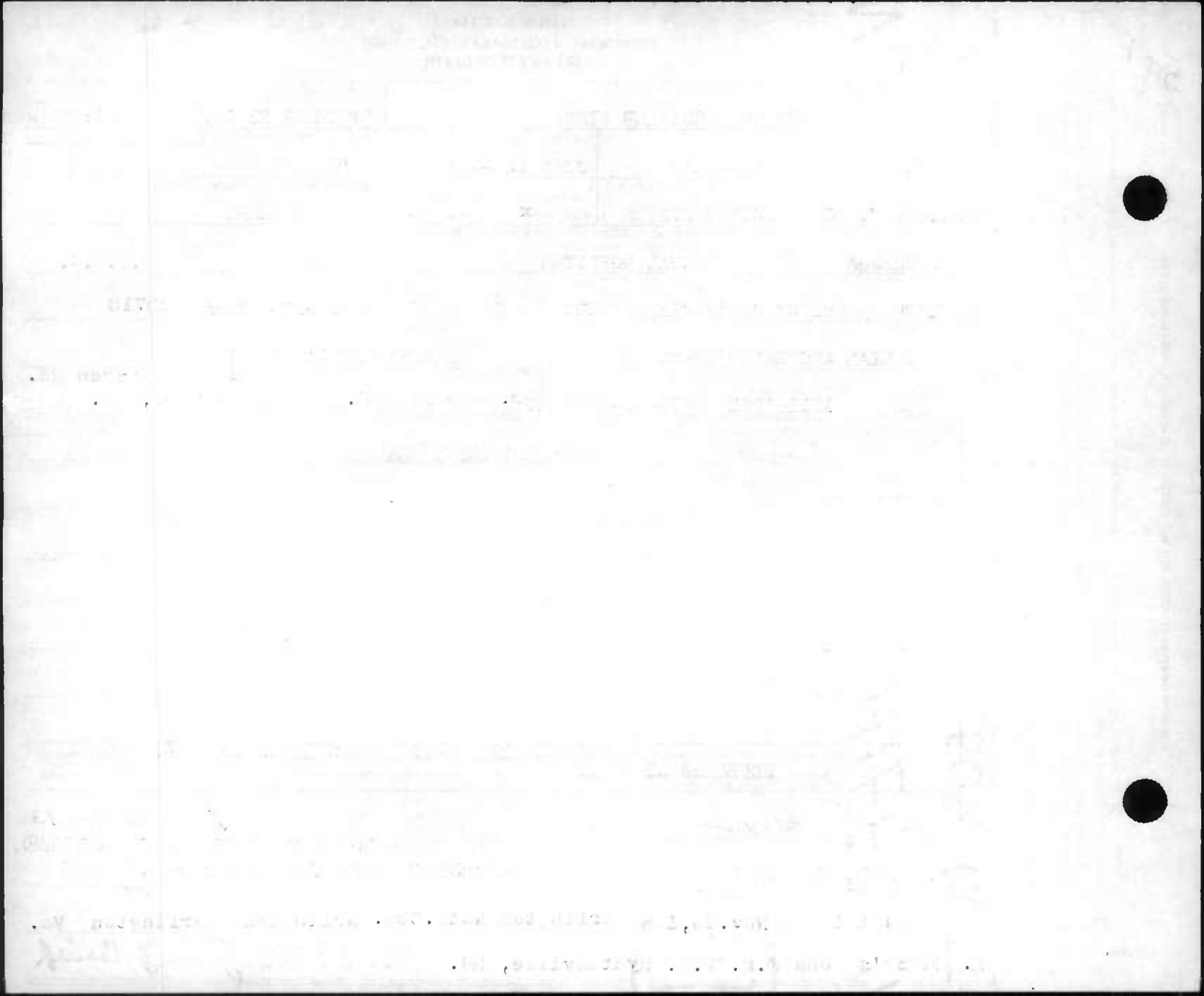
23c. NAME OF CEMETERY OR CREMATORY  
**Arlington Natl. Cem.**

23d. LOCATION CITY OR TOWN COUNTY STATE  
**Arlington Arlington Va.**

24. FUNERAL DIRECTOR  
**F. Gansch's Sons F.H. P.A. Hyattsville, Md.**

25a. DATE REC'D. BY REGISTRAR  
**NOV 28 1983**

25b. REGISTRAR'S SIGNATURE  
**John J. Conner**



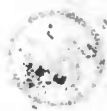
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. Pages 3 and 4 should be retained by the funeral director. Pages 1 and 2 should be retained by the funeral director. Pages 3 and 4 should be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 38		308					
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
William Howard Taylor, SR				Nov 5 1983		8:38		A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Male		White		January 7, 1910		73 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
North Carolina		USA				Montgomery MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Olney		Brooke Grove N.H.		Insurance-Broker		Desibour Assoc.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.		Mont.		S.S.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		15500 Layhill Road	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Charles		Ella		Yes		578 03 4415		Ruth Taylor (Wife) Same as #13E	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1940 DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CA - ADRENAL BONE 2 of 2 DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA LUNG. 2M.						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
ADVANCED C.O.P.D.				HOUR A.M. MONTH DAY YEAR					
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		CITY OR TOWN		COUNTY STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		STREET					
22a. I certify that (1) (this hospital) attended the deceased from 10/31/83 to 11/5/83, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not view the body after death, so state.)		22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
		Donald R. Lewis MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		11/5/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
D. R. LEWIS MD		Olney Md 20830		Burial		11/8/83		Cedar Hill	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. LOCATION		CITY OR TOWN COUNTY STATE	
Hines/Rinaldi 11800 New Hampshire Ave. S.S. Md.		NOV 9 1983		D. R. Lewis		Suitland PG Maryland			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30839

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nola M. Thomas			2a. DATE OF DEATH MONTH DAY YEAR November 11, 1983		2b. HOUR 9:10AM	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR May 7, 1903		
6. AGE (IN YEARS LAST BIRTHDAY) 80		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Montg.		13c. CITY OR TOWN Sandy Spring		
14. FATHER'S NAME FIRST MIDDLE LAST James Jones		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS Phyllis Carroll (Daughter) same As #13		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory Failure</u> 2387 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Deformed aortic</u> (c) <u>Myelodysplastic bone</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>3 yrs</u> <u>3 yrs</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTORSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE 64 11/11 83	
22a. I certify that (I) (this hospital) attended the deceased from <u>6/11/83</u> to <u>11/11/83</u> that (I) (I) saw the deceased alive on <u>11/11/83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <u>Charles H. Ligon</u>		DEGREE <u>MD</u>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles H. Ligon, M. D.		22e. ADDRESS 18111 Prince Philip Dr. Olney, Maryland 20832			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-16-83		23c. NAME OF CEMETERY OR CREMATORY Ash Memorial Cem.	
24. FUNERAL DIRECTOR NAME George R. Snowden		24b. ADDRESS 246 N. Washington St. Rockville, Md. 20850		25. DATE REC'D BY REGISTRAR NOV 17 1983	
23d. LOCATION CITY OR TOWN COUNTY STATE Sandy Spring, Montg. Md.		25b. REGISTRAR'S SIGNATURE <u>James J. Galt</u>			

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Nov 17 1903  
J. L. G. Giff



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30840

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>EDWARD D. THOMPSON</b>			2a. DATE OF DEATH MONTH <b>NOV</b> DAY <b>15</b> YEAR <b>83</b>		2b. HOUR <b>11.50</b> AM
3. SEX <b>M</b>	4. RACE <b>Can</b>	5. DATE OF BIRTH MONTH <b>Dec</b> DAY <b>27</b> YEAR <b>1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Illinois</b>	7b. CITIZEN OF WHAT COUNTRY? <b>US</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>Rockville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Potomac Valley Nursing Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PRINTER</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>PRINTING</b>	
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>MONTGOMERY</b>	13c. CITY OR TOWN <b>ROCKVILLE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST <b>EDWARD</b> MIDDLE <b></b> LAST <b>THOMPSON</b>			15. MOTHER'S MAIDEN NAME FIRST <b></b> MIDDLE <b></b> LAST <b>DIXON</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>1918</b>	17. INFORMANT <b>DANIEL R. THOMPSON, POTOMAC, MD.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest -</b> <b>4409</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b></b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. certify that (i) this hospital attended the deceased <b>11/15/83</b> to <b>11/15/83</b> , that (ii) we last saw the deceased alive on <b>11/15/83</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
22b. SIGNATURE <b>Henry C. Sorensen MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/15/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Henry C. Sorensen MD</b>		22e. ADDRESS <b>5413 Cedar La Bethesda Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11/19/1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. GABRIELS</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>POTOMAC MONTGOMERY MD.</b>
24. FUNERAL DIRECTOR NAME <b>RICHARD PAPP INC, WASH. D.C 20036</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 21 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

151A24-2

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1000. ATTACH PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 30841	
1- FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) <i>Julia Elizabeth Thompson</i>										2b. DATE KNOWN OF DEATH MATED <i>Nov 14 1983</i>	
2. SEX <i>Female</i>										2c. DATE PRONOUNCED DEAD <i>Nov 14 1983</i>	
3. RACE <i>Black</i>										2d. HOUR <i>1:50 PM</i>	
4. DATE OF BIRTH <i>July 9 1967</i>										2e. HOUR <i>1:50 PM</i>	
5. AGE (IN YEARS) <i>16</i>										2f. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery MD.</i>	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>										7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>										8. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>	
8. CITY OR TOWN OF DEATH <i>Tak Park Wash. Advent. Hosp</i>										9. KIND OF BUSINESS OR INDUSTRY <i>US Govt</i>	
9. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Wash. Advent. Hosp</i>										10. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <i>212 Prince Georges Hyattsville</i>	
11. CITY OR TOWN <i>Hyattsville</i>										12. STREET ADDRESS <i>988 Chillum Rd</i>	
12. FATHER'S NAME (TYPE OR PRINT) <i>Otis R. Ligon</i>										13. MOTHER'S MAIDEN NAME (TYPE OR PRINT) <i>Gertrude Johnson</i>	
13a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>no</i>										13b. SOCIAL SECURITY NO. <i>578-22-2846</i>	
14. INFORMANT (TYPE OR PRINT) <i>Thomas B. Thompson</i>										14. ADDRESS <i>Hyattsville, Md. 908 Chillum Rd.</i>	
15. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <i>4291 Acute Myocardial Disease</i> IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>None</i>											
16a. DATE OF OPERATION <i>None</i>				16b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>John Rogers</i>				TITLE (SPECIFY) <i>MD.</i>				DATE SIGNED <i>Nov 15 1983</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>John Rogers</i>				ADDRESS <i>7600 Carroll Ave. Takoma Park, Md</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>11-18-83</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cemetery</i>			
23d. LOCATION CITY OR TOWN <i>Brentwood, Maryland</i>				23e. COUNTY <i>Montgomery</i>				23f. STATE <i>MD.</i>			
24. FUNERAL DIRECTOR NAME <i>Marshall's Funeral Home Inc.</i>				ADDRESS <i>4217 9th St NW: Washington, D.C.</i>				NOV 18 1983			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				30842 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Robert W. Thompson, Jr.</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>Nov. 4 1983</i>				2b. HOUR <i>10:40 A</i>			
3. SEX <i>Male</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>August 26 1910</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>73</i>		7. UNDER 1 YEAR MONTHS DAYS <i>11 8 13</i>		8. UNDER 24 HRS. HOURS MIN. <i>10 40</i>	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.					
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>4012 Rickover Road</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Project Engineer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Industrial</i>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>				13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>4012 Rickover Road 20902</i>	
4. FATHER'S NAME FIRST MIDDLE LAST <i>Robert W. Thompson, Sr.</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>May Latimer</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>Yes WWIT</i>				16b. SOCIAL SECURITY NO. <i>163-24-2357</i>		17. INFORMANT <i>Wife Rachel B. Thompson</i>				ADDRESS <i>Same As 13</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of Pancreas</i> <i>1579</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 89</i> to <i>Nov 4 83</i> , that (I) (we) last saw the deceased alive on <i>Nov 3 83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Fred A Gill</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>11/8/83</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>FRED A GILL</i>				22e. ADDRESS <i>4743 BRADLEY BLVD CHEVY CHASE, MD 20815</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>Nov. 8, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Rockville Mont. Md.</i>			
24. FUNERAL DIRECTOR NAME <i>Francis J. Collins</i>				ADDRESS <i>500 University Blvd., W. Silver Spring, Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>NOV 14 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Givens</i>	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)FIRST MIDDLE LAST  
EDWARD J. THORNE2a. DATE OF DEATH MONTH DAY YEAR  
NOVEMBER 18 19832b. HOUR  
5:05 P M

3. SEX

MALE

4. RACE

NEGRO

5. DATE OF BIRTH

MONTH DAY YEAR  
APRIL 13 1897

6. AGE (IN YEARS LAST BIRTHDAY)

86

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

7a. BIRTHPLACE

CUBA

7b. CITIZEN OF WHAT COUNTRY?

CUBA

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

MONTGOMERY

MD.

10. CITY OR TOWN OF DEATH

BETHESDA

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
NAVAL HOSPITAL

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)

UNK

12b. KIND OF BUSINESS OR INDUSTRY

UNK

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

UNK

13b. COUNTY

UNK

13c. CITY OR TOWN

UNK

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS

UNK

99999

14. FATHER'S NAME

FIRST MIDDLE LAST  
UNK

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST  
UNK

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)  
no

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)  
020-98-9999

17. INFORMANT

ADDRESS

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

PROBABLE PANCREATIC NEOPLASM

DUE TO, OR AS A CONSEQUENCE OF

1579  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

NA

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED

IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐

AT WORK AT WORK

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 1, 1983, to NOVEMBER 18 1983, that (I) (we) lost  
saw the deceased alive on NOVEMBER 18 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

R. L. Sollock

DEGREE

ATTENDING  
PHYSICIAN ☐ MEDICAL  
DIRECTOR ☐ STAFF  
PHYSICIAN ☒

22c. DATE SIGNED

22 Nov 83

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

R. L. SOLLOCK, LCDR, MC, USN

22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND,  
NATIONAL CAPITAL REGION, BETHESDA, MD 20814

23a. BURIAL, CREMATION, REMOVAL

(SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

Marshall's Funeral Home

ADDRESS

4217 9th St NW: Washington, D.C.

25a. DATE REC'D. BY REGISTRAR

DEC 5 1983

25b. REGISTRAR'S SIGNATURE

John J. Conner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED  
JAN 10 1964  
U.S. AIR FORCE  
OFFICE OF THE  
JOINT CHIEFS OF STAFF  
WASHINGTON, D.C.



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHM-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 30844	
1. DECEASED NAME (TYPE OR PRINT) <b>W. MURRAY TODD</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>11</b> DAY <b>26</b> YEAR <b>1983</b>		2b. HOUR <b>0003</b> AM			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>10</b> DAY <b>23</b> YEAR <b>28</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>55</b> YRS.		7c. DATE PRONOUNCED DEAD MONTH <b>11</b> DAY <b>26</b> YEAR <b>1983</b>		2d. HOUR <b>0003</b> AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>CA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.					
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SHADY GROVE ADVENTIST HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Administrator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>InterScience</b>			
13a. STATE <b>MD</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>ROCKVILLE</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS <b>10109 LLOYD RD 20854</b>			
14. FATHER'S NAME FIRST <b>WALTER</b> MIDDLE <b>E.</b> LAST <b>Todd</b>						15. MOTHER'S MAIDEN NAME FIRST <b>GERALDINE</b> MIDDLE <b>MURRAY</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>				16b. SOCIAL SECURITY NO. <b>KOREA 545-36-7086</b>		17. INFORMANT ADDRESS <b>Judith W. Todd - SAME AS #13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> 4100 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>ARTERIOSELECTATIC CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>ACUTE</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR <b>11</b> P.M. MONTH <b>11</b> DAY <b>25</b> YEAR <b>1983</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>AWAKENED WITH CHEST PAIN</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>		21f. LOCATION STREET <b>10109 LLOYD RD</b> CITY OR TOWN <b>ROCKVILLE</b> COUNTY <b>MONTGOMERY</b> STATE <b>MD</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Francis C. Mayle</b>				TITLE (SPECIFY) <b>Dept</b>				DATE SIGNED <b>11/26/83</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Francis C. Mayle</b>				ADDRESS <b>8200 Wisconsin Ave Bethesda MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Nov. 28, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>				23d. LOCATION CITY OR TOWN <b>Suitland</b> COUNTY <b>Maryland</b> STATE			
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons Inc.</b>				25a. DATE REG'D. BY REGISTRAR <b>DEC 5 1983</b>				25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>			
5130 Wisc. Ave., N.W. Wash., D.C.											

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. IF THE DEATH IS SUSPECTED TO BE A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

30845

1- STATE REGISTRAR		FOR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST	
Julian		Turner	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)
Male	White	Mar. 6, 1893	90 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	
North Carolina		United States	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
Bethesda		5514 Lincoln Street	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Salesman		Real Estate	
13a. STATE		13b. COUNTY	
Maryland		Montgomery	
13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS		Zip: 20817	
5514 Lincoln Street			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
Julian A. Turner		Marie Leach	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.	
Yes WWII		085-01-2686	
17. INFORMANT		ADDRESS	
Lucy B. James, Great Niece,		301 Queen Street, Alexandria, Virginia	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a)			
4140 Cardiac arrest			
DUE TO, OR AS A CONSEQUENCE OF			
(b) Coronary arteriosclerosis			
DUE TO, OR AS A CONSEQUENCE OF			
(c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY?			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	
		P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
22b. TITLE (SPECIFY)			
ACTUAL SIGNATURE		DATE	
John Tamber		11-7-83	
EXAMINER'S NAME (TYPE OR PRINT)		MEDICAL EXAMINER	
John Tamber		309th Ave	
ADDRESS		8218 WISCONSIN AVE	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Cremation		November 9, 1983	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Metropolitan Crematory		Alexandria Virginia	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
Robert A. Humphrey Funeral Homes, P.A., Bethesda, Maryland		NOV 14 1983	
		25b. REGISTRAR'S SIGNATURE	
		John J. Connelley	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										30846			
1- FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>GERALD WALTER URBANCIK</b>										2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>NOV 22 19 83</b>		2b. HOUR MIN <b>352 PM</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 27 1944</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>39 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>NOV 22 19 83</b>		2d. HOUR MIN <b>352 PM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ILLINOIS</b>				7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>U. S. ARMY</b>				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>CHEVY CHASE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>4242 EAST-WEST HIGHWAY</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>WALTER J. URBANCIK</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MICHALINE M. KUROWSKI</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>						16b. SOCIAL SECURITY NO. <b>332-36-3778</b>		17. INFORMANT ADDRESS <b>Michaline M. Kurowski Trail, San Antonio, Texas</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MULTIPLE TRAUMA</b> 9571 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>ACUTE</b>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):													
19a. DATE OF OPERATION —				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? —						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>11 22 19 83</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2) <b>JUMPED FROM BUILDING</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>PARKING GARAGE</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>US. NAVAL HOSP BETHESDA MONT MD</b>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>Francis C. Mayle</i>				TITLE (SPECIFY) <b>DEPT</b>				DATE SIGNED <b>11/23/83</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>FRANCIS C. MAYLE, MD</b>				ADDRESS <b>8200 WISCONSIN AVE., BETHESDA, MD</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>				23b. DATE <b>11-26-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Szykowmy Funeral Home</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Chicago Illinois</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>MARSHALL FUNERAL HOME Washington, DC</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1983</b>				REGISTRAR'S SIGNATURE <i>J. Canale</i>					

BP

Nov 5 1883



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 30847		
1. DECEASED NAME (TYPE OR PRINT) <b>Harold D. Vanderbeek</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>11/27/83</b>			2b. HOUR <b>4:45 P</b>				
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>08 28 03</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b>		7. UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		8. IF UNDER 24 HRS. HOURS MIN. <b>4:45 P</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>						
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Driver</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Fuel Oil Company</b>				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>					13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Kensington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3919 Wexford Drive 20895</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>David Vanderbeek</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rachel Casper</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>143-01-8874</b>		17. INFORMANT <b>Daughter</b>		ADDRESS <b>Same as 13</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized Arteriosclerosis</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Chronic Obstructive pulmonary disease, Aspiration pneumonia</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 82</b> , 19 <b>82</b> , to <b>Nov 27</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>Nov 27</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Bernard A. Fitzgerald MD</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11/27/83</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BERNARD A. FITZGERALD</b>				22e. ADDRESS <b>217 University Blvd. E, Silver Spring, MD 20901</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>REMOVAL</b>		23b. DATE <b>NOV. 29, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arroyo Grande Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arroyo Grande Calif.</b>						
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b>				ADDRESS <b>500 University Blvd., W. Silver Spring, Md.</b>				25. DATE REC'D. BY REGISTRAR <b>DEC 6 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connelley</b>		

1. Subject Head

2. Object to

3. Place of

4. Time of

5. Person to

6. Subject to

7. Object to

8. Place of

9. Time of

10. Person to

11. Subject to

12. Object to

13. Place of

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/82  
(VRA 15, 4)

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VERNON (NMN) VANN			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 2, 1983		2b. HOUR 3:00 a.m.						
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR FEB. 15, 1957		6. AGE (IN YEARS LAST BIRTHDAY) 26 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY, MD.					
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CLINICAL CENTER (NIH)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY GSA			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN VIRGINIA Arlington ARLINGTON						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4600 S. FOUR MILE RUN 22204			
14. FATHER'S NAME FIRST MIDDLE LAST Ivie Lee Vann						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lola Beard					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 246-15-0461		17. INFORMANT ADDRESS MRS. LOLA VANN (MOTHER) RT. 4, Box 291 CLINTON, NC 28328							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMOCYSTIS CARINI 1363 DUE TO, OR AS A CONSEQUENCE OF (b) ACQUIRED IMMUNE DEFICIENCY SYNDROME Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) KAPOSI SARCOMA										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from OCT. 12, 1983, to NOV. 2, 1983, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on NOV. 2, 1983, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.											
22b. SIGNATURE George Wilding MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 11/2/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE WILDING				22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MD 20205							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-5-83		23c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton, N.C.					
24. FUNERAL DIRECTOR Marshall's Funeral Home 4217 9th St. NW, Washington, D.C.				25a. DATE REC'D. BY REGISTRAR NOV 7 1983		25b. REGISTRAR'S SIGNATURE John J. Conner					

MEDICAL CERTIFICATION



RECEIVED  
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WASHINGTON, D.C.

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June 24, 1964

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30849

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Fred A. VanSickle</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 15, 1983</b>		2b. HOUR MIN. <b>8:00 P</b>	
3. SEX <b>Male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 6, 1888</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>95</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>804 Maple Avenue</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Minister</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Methodist</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Rockville</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>804 Maple Ave. 20850</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Winfield Scott Van Sickle</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Evealine Hazen</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>220 34 3768</b>		17. INFORMANT ADDRESS <b>Josephine M. Van Sickle same as 13e</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> <b>2639</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Dehydration</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>malnutrition</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18a <b>S/P CVA</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY P.M. <b>10:45 A.M. 10-4-83</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>10-4-78</b> to <b>11-15-83</b> , that (I) (we) last saw the deceased alive on <b>11-3-83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>B.S. Kim</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-15-83</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KWANG S. KIM</b>		22e. ADDRESS <b>11119 Rockville Pike, Rockville, MD. 20852</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/19/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Burtonsville Cemetery</b>		23d. LOCATION <b>Burtonsville, Maryland</b> STATE
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home, Inc.</b> <b>1331 Rockville Pike Rockville, Md. 20852</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 21 1983</b>		

25b. REGISTRAR'S SIGNATURE

*[Faint, illegible handwritten notes]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or one of the following:

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30850

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MANUEL VICENTE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-25-83</b>		2b. HOUR <b>8:30 AM</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>March 3 1928</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Spain</b>	7b. CITIZEN OF WHAT COUNTRY? <b>Perma. Resident</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. <b>BALTIMORE CITY OR</b> COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>S.S.</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2109 Dexter Avenue</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Shoemaker-David Stern</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>		13b. COUNTY <b>Mont.</b>	13c. CITY OR TOWN <b>S.S.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>2109 Dexter Avenue</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Hosea B Vicente</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Encarnacion Lesende</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>None</b>		16b. SOCIAL SECURITY NO. <b>137 50 3518</b>		17. INFORMANT ADDRESS <b>Melida Vicente (Wife) Same as 13E</b>	

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory FAILURE</b> <b>1629</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>LUNG CANCER</b> (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b> <b>1 year</b>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

**Chronic Obstructive Pulmonary Disease**

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11/23 1983</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/23 1983</b> to <b>11/25 1983</b> , that (I) (we) lost above, (I) (we) did not view the body after death.			
22b. SIGNATURE <b>Daniel Rosenblum</b>		DEGREE <b>MD</b>	22c. DATES SIGNED <b>11/25/83</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DANIEL ROSENBLUM</b>		22e. ADDRESS <b>10400 CONNECTICUT AV KENSINGTON, MD 20895</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>11/28/83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>S.S. Mont. Maryland</b>
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi 11800 New Hampshire Ave. S.S. Md</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1983</b>	25b. REGISTRAR'S SIGNATURE <b>John J. Lander</b>

STATE OF NEW YORK  
IN SENATE  
JANUARY 10, 1901.

REPORT OF THE  
COMMISSIONER OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE  
JANUARY 10, 1901.

ALBANY: J. B. LIPPINCOTT & CO. PRINTERS.  
1901.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) George Thornton Viverette			2a. DATE OF DEATH MONTH DAY YEAR 11/19/83			2b. HOUR 11:05 P. M.				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 21 1915			6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Maryland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1337 Chilton Drive,			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Director of Services		12b. KIND OF BUSINESS OR INDUSTRY AAA			
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST G. G. Viverette			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Whitehead							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Margaret I. Viverette-wife- (same as 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma lung</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 21/1/83		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>2/5</u> 19 <u>83</u> to <u>11/19</u> 19 <u>83</u> that (I) (we) lost saw the deceased alive on <u>11/2</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.										
22b. SIGNATURE <u>S. Dean M.D.</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/19/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDGAR H. LEVIN, MD					22e. ADDRESS 8230 PENTON St. S.S. Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-22-83		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Md.			
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home					11800 N.H. Ave., Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR NOV 22 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>	

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 30852			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST LILLIAN K. VOGEL				NOVEMBER 3, 1983			
3 SEX FEMALE				5. AGE (IN YEARS LAST BIRTHDAY) 84			
4 RACE WHITE				6. A. AGE (IN YEARS LAST BIRTHDAY) 84			
5. DATE OF BIRTH FEBRUARY 6, 1899				7. BIRTHPLACE (STATE OR FOREIGN) NEW YORK			
8. CITIZEN OF WHAT COUNTRY? U.S.A.				9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.			
10. CITY OR TOWN OF DEATH ROCKVILLE				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) POTOMAC VALLEY NURSING HOME			
12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE				13. KIND OF BUSINESS OR INDUSTRY OWN HOME			
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 14a. STATE MARYLAND				14b. COUNTY MONTGOMERY			
14c. CITY OR TOWN ROCKVILLE				14d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14e. STREET ADDRESS 6111 MONTROSE ROAD				14f. STREET ADDRESS 20852			
15. FATHER'S NAME FIRST MIDDLE LAST ABRAHAM KARMEL				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY (UNASCERTAINABLE)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 578-46-9354			
17. INFORMANT ADDRESS MRS. BEVERLY VOGEL, OLNEY, MARYLAND				17. INFORMANT ADDRESS 3224 LLEWELLYN FIELD RD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Cardio-pulmonary Arrest</u> 4292 DUE TO, OR AS A CONSEQUENCE OF 18b. <u>Dissecting Aortic Aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF 18c. <u>Dissecting Aortic Aneurysm</u> Approximate interval between onset and death 3yr							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>4/27</u> 19 <u>83</u> to <u>11/3</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>11/3</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.							
22b. SIGNATURE <u>Myron L. Lenkin</u>				22c. DATE SIGNED 11/4/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. MYRON LENKIN, M. D.				22e. ADDRESS 2309 SHOREFIELD ROAD WHEATON, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL BURIAL				23b. DATE 11/6/1983			
23c. NAME OF CEMETERY OR CREMATORY MOUNT LEBANON CEMETERY				23d. LOCATION ADELPHI, PRINCE GEORGE'S, MD.			
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.				25. DATE REC'D. BY REGISTRAR NOV 10 1983			
25. REGISTRAR'S SIGNATURE <u>John J. Casper</u>				25. REGISTRAR'S SIGNATURE			

BP

James G. Thompson

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 8 5 3

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST <b>MARTHA</b> MIDDLE <b>DOOLEY</b> LAST <b>WALDO</b>				2a. DATE OF DEATH MONTH <b>11</b> DAY <b>16</b> YEAR <b>1983</b> 2b. HOUR <b>10<sup>30</sup></b> P.M.			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>Oct.</b> DAY <b>24</b> YEAR <b>1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Tenn.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Chevy Chase Retirement &amp; Nursing Cen.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	
13a. STATE <b>D.C. 20015</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Joseph</b> MIDDLE <b>Dooley</b> LAST <b>Dooley</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Belle</b> MIDDLE <b>Thomas</b> LAST <b>Thomas</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>517-38-8716 D</b>		17. INFORMANT ADDRESS <b>Washington, D.C.</b> <b>3411 Quesada St., N.W.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro Vascular Accident</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>WEEKS</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>July 19 83</b> to <b>late</b> 19 <b>83</b> , that (1) (over) lost saw the deceased alive on <b>11/16/83</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did) (did not) view the body after death.							
22b. SIGNATURE <b>Thos G. Ward</b>				22c. ADDRESS <b>6116 Robinwood, Bethesda, Md 20817</b>		22d. DATE SIGNED <b>11/16/83</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>11/18/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland Maryland.</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons Inc.</b> <b>5130 Wisc. Ave., N.W/ Wash., D.C.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 21 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

3 0 8 5 4

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>CYNTHIA L WALKER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 18 83</b>		2b. HOUR <b>11:05 PM</b>		
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 26 54</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>29</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>TEXAS</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Montg. Co. Govt</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montg.</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Wesley C. Walker</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marion A. Wood</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-66-4227</b>	
17. INFORMANT ADDRESS <b>Marion Wood (mother) Same AS # 13</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Esophageal Variceal Hemorrhage.</b> 5715 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hepatic Coma.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CIRRHOSIS, IDIOPATHIC</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY.</b> <b>5 DAY.</b> <b>10 YEARS</b>			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  
**COAGULOPATHY.**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>11/18</b> 19 <b>83</b> , to <b>11/18</b> 19 <b>83</b> , that (1) (we) last saw the deceased alive on <b>11/18</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Alan J. Diamond</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/19/83.</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALAN J. DIAMOND</b>				22e. ADDRESS <b>1106 SPRING ST. SILVER SPRING, MD.</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11-23-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Montg Md.</b>	
24. FUNERAL DIRECTOR NAME <b>George R. Snowden</b>		24a. ADDRESS <b>246 A. WASH. ST. Rockville, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 22 1983</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED  
JAN 2 1900  
U.S. DEPT. OF AGRICULTURE

TO THE  
HONORABLE  
COMMISSIONER OF THE  
LAND OFFICE  
WASHINGTON, D.C.

THE  
LAND OFFICE  
WASHINGTON, D.C.



RECEIVED  
JAN 2 1900  
U.S. DEPT. OF AGRICULTURE



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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) DAVID EARL WARD			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 23 1983		2b. HOUR 1:20 P.M.
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR NOVEMBER 3 1932	6. AGE (IN YEARS LAST BIRTHDAY) 51	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MINNESOTA	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED	12b. KIND OF BUSINESS OR INDUSTRY U.S.A.F.		
13a. STATE DELAWARE		13b. COUNTY KENT	13c. CITY OR TOWN CAMDEN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 210 CAMBRIDGE ROAD 99999
14. FATHER'S NAME FIRST MIDDLE LAST VIRGIL EARL WARD		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNIE BARTOW WOODS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1955-1975	17. INFORMANT ADDRESS 19934 BETTY LOU WARD, 210 CAMBRIDGE ROAD, CAMDEN, DE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from November 22, 1983, to November 23, 1983, that (I) (we) lost saw the deceased alive on November 23, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Eugene S. Killeavy M.D.		DEGREE L.M.C.		22c. DATE SIGNED 25 Nov 83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. KILLEAVY, LT, MC, USN		22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814			
23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE Nov 28, 1983	23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem	23d. LOCATION City or Town Arlington	COUNTY Va.	STATE
24. FUNERAL DIRECTOR NAME William C Tocher		25a. DATE REC'D. BY REGISTRAR DEC 2 1983		25b. REGISTRAR'S SIGNATURE John J. Canine	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
I. DECEASED NAME		DATE		HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		HRS MIN.	
NINA M. WARD		11 1 83		9:20 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. BALTIMORE CITY OR COUNTY OF DEATH	
Female	White	MONTH DAY YEAR	96	MONTGOMERY MD	
7a. BIRTHPLACE	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	12a. USUAL OCCUPATION		
West Virginia	USA		Retired manager Cafeteria		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12b. KIND OF BUSINESS OR INDUSTRY		
SILVER SPRING	HOLY CROSS HOSPITAL				
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	14. STREET ADDRESS	
Maryland	Montgomery	Kensington	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	10001 Crestwood Road 20895	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
James A. Moody		Mary J. Pickens			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		578-14-0701		Charles S. Ward same as 13c	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Massive Pulmonary Embolus					
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Coronary Artery Disease					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED	
(IF EITHER, NOTIFY MEDICAL EXAMINER)		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7/10/82, 1982, to 1/1/83, 1983, that (I) saw the deceased alive on 1/1/83, 1983, and that in my opinion death occurred on the date and hour and from the causes stated above. (If (we) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Michael Cross		MD		1/1/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
R. C. O'Flaherty		10620 G Ave SS and			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		11/4/83		Oak Hill Cemetery	
23d. LOCATION		23e. DATE REC'D. BY REGISTRAR			
Washington, D.C.		NOV 4 1983			
24. FUNERAL DIRECTOR		25a. REGISTRAR'S SIGNATURE			
Tyson Wheeler Funeral Home, Inc.		John J. Lamer			
1331 Rockville Pike, Rockville, Md. 20852					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30857

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>IRIS Carter Marsh WARING</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 25 1983</b>			2b. HOUR <b>5:30 P.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 2 1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>89</b>		7. IF UNDER 1 YEAR HOURS MIN. <b>5:30 P.M.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Tennessee</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Fairland Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Singer Sewing Co.</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. STREET ADDRESS / ZIP CODE <b>2212 Arcola Avenue 20902</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas B. Carter</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alice Lester</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>411-40-9457</b>		17. INFORMANT ADDRESS <b>Sylvia Vengrouskie Daughter Same as 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>4912</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic obstructive bronchitis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Organic brain syndrome</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
<b>Organic brain syndrome</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>April 1982</b> to <b>Nov 25 1983</b> , that (I) (we) lost saw the deceased alive on <b>Nov 12 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Sydney Leventhal, M.D.</b>				DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>11/26/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Sydney Leventhal, M.D.</b>				22e. ADDRESS <b>Silver Spring, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 29, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Clapps Chapel Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Carrutan Tennessee</b>			
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b>				ADDRESS <b>500 University Blvd., W. Silver Spring, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 2 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John D. Smith</b>	



9-10-12

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 10th inst. and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Yours very truly,  
[Signature]

Very truly yours,  
[Signature]

Enclosed for you are the following documents:

1. A copy of the report of the Committee on the subject of the proposed amendment to the Constitution of the United States.

2. A copy of the report of the Committee on the subject of the proposed amendment to the Constitution of the United States.

I am, Sir, very respectfully,  
Yours very truly,  
[Signature]

Very truly yours,  
[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 42 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

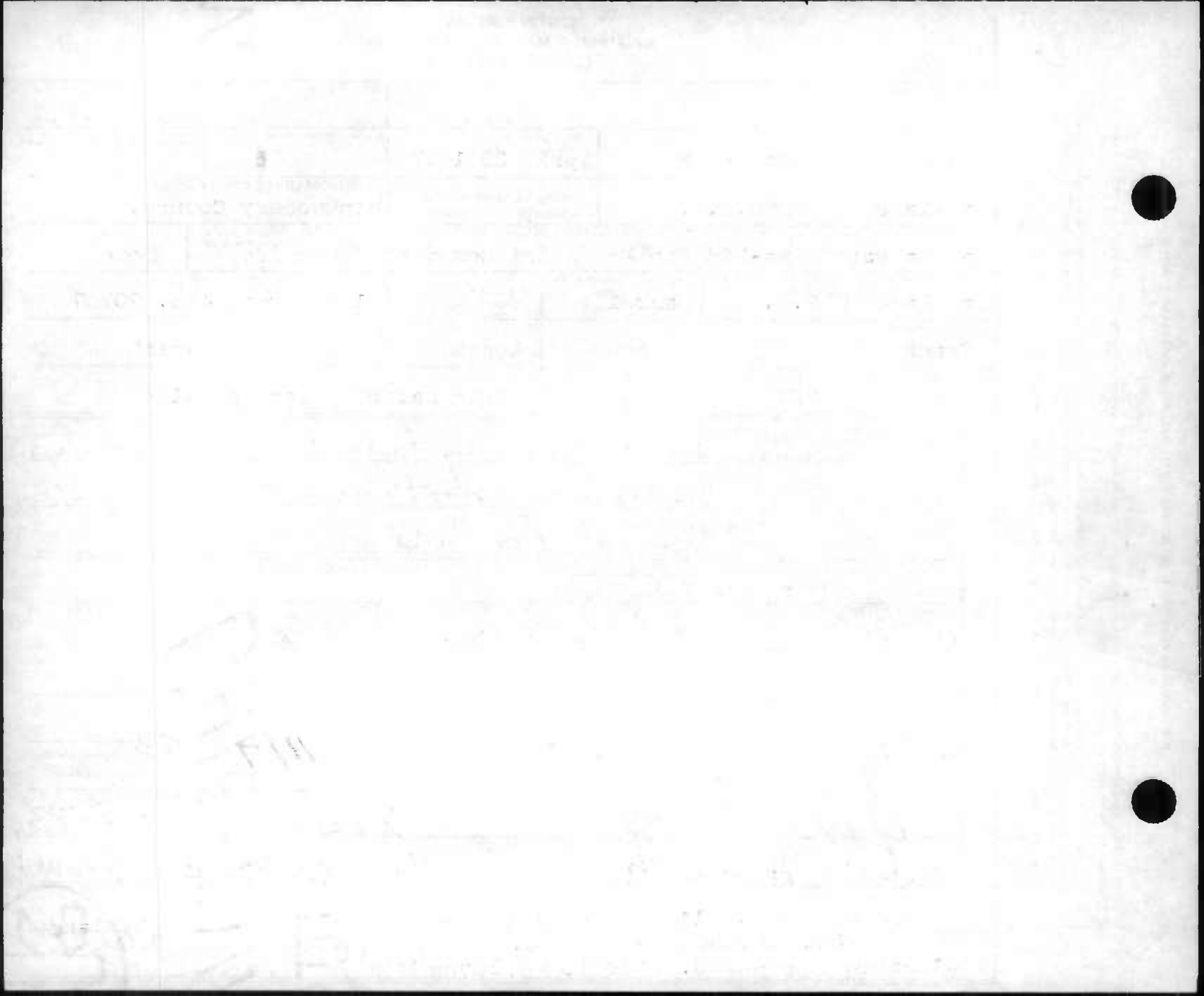
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30858

1. DECEASED NAME (TYPE OR PRINT) Blanche Virginia Warner			2a. DATE OF DEATH MONTH DAY YEAR 11-7-83		2b. HOUR 11:32 PM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 29 1897		
6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.				
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		
12b. KIND OF BUSINESS OR INDUSTRY Home		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY P.G. 13c. CITY OR TOWN Laurel				
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8104 Gorman Ave. 20707				
14. FATHER'S NAME FIRST MIDDLE LAST Frank Merson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Smith				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES-NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES-GIVE WAR OR DATES) NONE		17. INFORMANT ADDRESS Morton Warner Same as #13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1749 IMMEDIATE CAUSE (a) Cardiorespiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Breast Cancer DUE TO, OR AS A CONSEQUENCE OF (c) Renal Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 Days 1 yr						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pneumonia						
19a. DATE OF OPERATION 10-28-83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Breast Biopsy		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 10-24-83 to 11-7-83, that (I) (we) lost the deceased alive on 11-7-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.						
22b. SIGNATURE Robert A. Smith		22c. DATE SIGNED 11-8-83		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Robert A. Smith		22f. ADDRESS 831 University Blvd E S.S. Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 11 83		23c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Laurel Maryland		24. FUNERAL DIRECTOR NAME FLECK FUNERAL HOME, INC. ADDRESS 7601 Sandy Spring Rd. Laurel, Md. 20707				
25a. DATE REC'D. BY REGISTRAR NOV 10 1983		25b. REGISTRAR'S SIGNATURE John J. Smith				

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 50M 4/B2  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30859

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Regina WARTSKI			2a. DATE OF DEATH MONTH DAY YEAR 11 16 83			2b. HOUR 3:44 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 15, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Yitzhak Grabin			15. MOTHER'S MAIDEN NAME MIDDLE LAST Moszkomic			16. ADDRESS Same as No. 13			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-80-5421		17. INFORMANT Jack Wartski		18. ADDRESS Same as No. 13			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>ANOXIC BRAIN INJURY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>CORONARY HEART DISEASE</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immed.</u> <u>3 days</u> <u>7 years</u>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b): <u>DIABETES Mellitus ; Non-Specific infectious process</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11-8</u> , 19 <u>83</u> , to <u>11-16</u> , 19 <u>83</u> , that <u>(we)</u> lost <u>saw</u> the deceased alive on <u>11-16</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>William Kurstin MD</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11/16/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>WILLIAM KURSTIN, MD</u>				22e. ADDRESS <u>1145 19th St. NW WASH. DC</u>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>11/18/83</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mount Lebanon</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Adelphi, Pr. Geo., Maryland</u>	
24. FUNERAL DIRECTOR NAME <u>D.M. Stein Hebrew Memorial F</u> <u>232 Carroll St., N. W. Washington,</u>				25a. DATE REC'D. BY REGISTRAR <u>NOV 21 1983</u>			
				25b. REGISTRAR'S SIGNATURE <u>John J. Canine</u>			

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

MEMORANDUM FOR THE DIRECTOR

DATE: 10/10/68

TO: DIRECTOR, FBI (100-388610) FROM: SAC, NEW YORK (100-100000) (P)  
SUBJECT: [REDACTED] (NY 100-100000) (P)

RE: [REDACTED] (NY 100-100000) (P)  
[REDACTED] (NY 100-100000) (P)

100-100000

100-100000

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30860

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST Emanuel Wattenberg			MONTH DAY YEAR 11 - 20 - 83			123 P M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Male	Caucasian	MONTH DAY YEAR 9 - 01 - 21	62 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
New York	USA.		Montgomery MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring	Holy Cross Hospital		Sales			Sears		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		
Maryland	Mont.	Silver Spring				3508 Twin Branches Court 20906		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST Morris Wattenberg		FIRST MIDDLE LAST Anna Bernstein						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
Yes No <input checked="" type="checkbox"/> WW II		050 16 1653		Beatrice J. Wattenberg See #13 Above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2898 MYEZO FIBROSIS DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 1/2 YRS.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from 11/7, 19 83, to 11/20, 19 83, that (2) (we) lost saw the deceased alive on 11/20, 19 83, and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED	
MARJORIE A. VOITH		MD					11/20/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS						
MARJORIE A. VOITH		106 IRVING ST. NW SUITE 421 WASHINGTON, D.C. 20010						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial		Nov 22 1983		Judean Mem. Park		Olney Maryland		
24. FUNERAL DIRECTOR NAME				ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Ives-Pearson Funeral Homes				Falls Church, VA.		NOV 25 1983		John J. Carver

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Handwritten text in the lower section of the page, including what appears to be a signature or name.

Handwritten text at the bottom of the page, possibly a date or reference.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE Webb CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR <b>Wanda</b>		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) <b>Wanda Webb</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>11-28-83</b>		2b. HOUR <b>10:10 AM</b>		
3. SEX <b>Female</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9-29-05</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Instructor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Pvt. School</b>	
13a. STATE <b>Md. 20815</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Chevy Chase</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3903 Leland St. 20815</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>DeWitt C. Webb</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Florence Brooks</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-44-2530</b>		17. INFORMANT ADDRESS <b>Emma Jean Webb Same as Item # 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>coronary arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <b>Sept 11, 1983</b> , to <b>11-28, 1983</b> , that (I) (we) last saw the deceased alive on <b>11-28, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>John J. Tauber MD</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11-28-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John Tauber</b>		22e. ADDRESS <b>Bethesda Md. 8218 WISCONSIN AVE</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, MD</b>			
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b> NAME <b>5130 Wisc. Ave. N.W. Wash., DC 20016</b> ADDRESS				25a. DATE REC'D BY REGISTRAR <b>DEC 2 1983</b> REGISTRAR'S SIGNATURE <b>John J. Tauber</b>					

BP

*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "Instructor" and "Station" are faintly visible.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>NORMAN W. Wehland Jr.</b>			20. DATE OF DEATH MONTH DAY YEAR <b>11 7 83</b>			26. HOUR <b>6<sup>23</sup> PM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 23 19</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONT. HOWARD - COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>OLNEY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MONTGOMERY Gen'l Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CONSTRUCTION</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. COUNTY <b>HOWARD</b>		13c. CITY OR TOWN <b>HIGHLAND</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>late Benjamin F. Wehland</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>late Anna M.</b>		16. ADDRESS <b>Mrs Helen Wehland 12772 Scaggsville Rd. Highland Md</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW 11 705 14 0430</b>		17. INFORMANT <b>Mrs Helen Wehland</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4100 IMMEDIATE CAUSE (a) CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>PREVIOUS MYOCARDIAL INFARCTION</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <b>7</b> <b>12/7</b> <b>19</b> <b>83</b> , to <b>11/7</b> <b>19</b> <b>83</b> , that (1) (we) lost saw the deceased alive on <b>12/7</b> <b>19</b> <b>83</b> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Everett Jackson, MD</b>		DEGREE		22c. DATE SIGNED <b>11/7/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EVERETT JACKSON, MD</b>		22e. ADDRESS <b>5340 TEN OAKS RD. CLARKSVILLE, MD</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov 10, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Pauls Church Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Fulton Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Harry H Witzke 4112 Columbia Rd Ellicott City</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 9 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connelley</b>	



Norman W. Wehland Jr.

Wm

Hal

Maryland

Gen'l Hospital

Late Anna M.

Late Benjamin F. Wehland

705 14 0430 Mrs Helen Wehland 12775 Seabreeze Road  
Baltimore, Maryland

Yes  
WM II

20% COTTON

Wilson Maryland

Nov 10, 1983 St Pauls Church, Conn

Berlin

Harry H Wicks 4112 Columbia Rd Ellicott City



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>RACHAEL WEIMER</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 27, 1983</b>		2b. HOUR <b>2 P.M.</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>CAUC.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 4, 1904</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENN.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>79</b>	
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2404 CHURCHILL RD</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD.</b>	
13a. STATE <b>PENN.</b>		13b. COUNTY <b>NORTHAMPTON</b>		13c. CITY OR TOWN <b>BETHLEHEM</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>BRADY C. HOFFMAN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNIE AXHORN</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>185-24-7191</b>		17. INFORMANT ADDRESS <b>JANICE UMLSTEFF 2404 CHURCHILL RD SIL. SPG. MD. 20902</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Advanced metastatic breast ca</b> 1749 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>10-20, 1983</b> , to <b>11-27, 1983</b> , that (I) (we) last saw the deceased alive on <b>11-5-83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>George H. Sengstack</b>				22c. DATE SIGNED <b>11-27-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GEORGE SENGSTACK</b>				22e. ADDRESS <b>COLUMBIA BLVD. SILVER SPRING MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>DEC. 1, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BETHLEHEM MEM. PARK</b>	
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>		500 <sup>DE</sup> UNIV. BLVD. W. SIL. SPG. MD. 20901		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BETHLEHEM NORTHAMPTON PA.</b>	
23e. DATE REC'D. BY REGISTRAR <b>DEC 2 1983</b>				23f. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	

MEDICAL CERTIFICATION

FRANCIS J. COLLINS

271. 270. 100. 10001

DEC

LEGAL

BETHLEHEM, PA. TARK

BETHLEHEM, NORTHAMPTON, PA.

GEORGE

SEKSTACH

COLUMBIA, ST. STEPHEN, ST. M.

TRAY

C.

NOTTAM

WHITE

WILKIN

NO

100-24-7191

JANICE WILSTEFF

271. 270. 100. 10001

271. 270. 100. 10001

TEMP.

NOTTAMPTON, DET. LITON

271. 270. 100. 10001

STIVER STRING

2404 CHURCHILL RD

HOMELANDER

CATERPILLAR CO.

TEMP.

U.S.A.

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MONTGOMERY

FEMALE

CALIF.

MAY 6, 1964

70

MICHAEL

WETTER

NOVEMBER 27, 1962

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 50M 4/82  
(VRA 15, 4)1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

3 0 8 6 4

1. DECEASED NAME (TYPE OR PRINT) <b>FIRST MIDDLE LAST</b> <b>PAUL CHARLES WELSH</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 29 83</b>		2b. HOUR <b>9<sup>55</sup> A M</b>		
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 15 03</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2315 Glenallen Avenue</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Composer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Army Map Service</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Apt. 101 2315 Glenallen Ave., 20906</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Richard J. Welsh</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Friel</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE DATE OF BIRTH) <b>WW 11 579-10-0748</b>		17. INFORMANT ADDRESS <b>Mary L. Welsh-sister-(same as 13e)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ALZHEIMER'S DISEASE</b> <b>3310</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>4/6</b> 19 <b>83</b> , to <b>10/29</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>10/10</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Mark H. Sig</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/30/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARK H. SIG</b>		22e. ADDRESS <b>5801 Georgia Ave Silver Spring Md</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-1-1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Montgomery Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi Funeral Home</b>		ADDRESS <b>11800 N.H. Ave.,</b>		25a. DATE REC'D. BY REGISTRAR <b>Oct 31 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Lauer</b>	

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 Montgomery

Silver Spring 2015 Glenallen Avenue Corporation  
 Maryland Montgomery Silver Spring  
 Richard J. Walsh  
 2015-12-12  
 2015 Glenallen Ave., 20908  
 April 101  
 Atty Gen Service  
 Filed  
 Mary  
 Mary L. Walsh-Atty Gen (12-12-15)

11-1-1983  
 11300 N.E. Ave.,  
 Silver Spring, Md.  
 Silver Spring Montgomery Md.  
 11300 N.E. Ave.,  
 Silver Spring, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30865

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>John K. Westerman</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-5-83</b>			2b. HOUR <b>11 A.M.</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 12, 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>84</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Gaithersburg</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Wilson Health Care Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired <del>Ins</del> Ins</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Agent</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Gaithersburg</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>403 Russell Ave 20877</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry C Westerman</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Schutt</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>212-07-2941</b>		17. INFORMANT <b>Mrs Evelyn Westerman</b>			ADDRESS <b>Same As 13e</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asystole</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>A.S.I.D.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>C.V.D. - Gen'l atherosclerosis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Seconds</b> <b>Years</b> <b>Years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Carcinoma of Prostate.</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 <b>80</b> to <b>11-5</b> , 19 <b>83</b> , that (I) <del>lost</del> lost saw the deceased alive on <b>11-4</b> , 19 <b>83</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) view the body after death.									
22b. SIGNATURE <b>Jack Schumacher M.D.</b> DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-5-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Leonard J Ruck Inc. Baltimore, Maryland</b>						22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11/8/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ioudon Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Leonard J Ruck Inc. Baltimore, Maryland</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 7 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Gierh</b>	



*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]*

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20% CO

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST LEAH		MIDDLE B		LAST WETMORE		2a. DATE KNOWN OF DEATH MONTH DAY YEAR ESTIMATED 11/13/83				2b. HOUR 11:43 am	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 8-08-94		6. AGE (IN YEARS) LAST BIRTHDAY 89 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11/13/83		7d. HOUR 11a 43 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Wash DC		13b. CITY OR TOWN Wash. DC		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 3636 Fessenden St NW				99999 20008			
14. FATHER'S NAME FIRST MIDDLE LAST Azariah Bass				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Blanchard									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 579 42 9919				17. INFORMANT Daughter Margaret W. Powell Same as 13c					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8880 IMMEDIATE CAUSE (a) Pulmonary Embolus DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Fracture of Hip DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 days													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None													
19a. DATE OF OPERATION 10-24-93				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Fracture Hip								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10 24 93				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fell at home					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE John S. Rogers, M.D.				TITLE (SPECIFY) M.D. Dep.				MEDICAL EXAMINER DATE SIGNED 11/13/1983 20910					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Nov. 15, 1983		23c. NAME OF CEMETERY OR CREMATORY National Memorial Park				23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church Virginia			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland						25a. DATE REC'D. BY REGISTRAR NOV 14 1983				25b. REGISTRAR'S SIGNATURE John S. Rogers			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 30861			
1. DECEASED NAME (TYPE OR PRINT) <b>John Leonard Whittaker</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 2, 1983</b>			
3 SEX <b>Male</b>				4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 4, 1894</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b>		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>				10. CITY OR TOWN OF DEATH <b>Rockville</b>			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Rockville Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>retired owner- grocery store</b>			
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles C. Whittaker</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ella Lewey</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>232-38-0625</b>		17. INFORMANT ADDRESS <b>Charles R. Whittaker same as 13c</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> <b>4920</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Emphysema</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>10-2-1986</b> to <b>10-21-1983</b> , that (I) (we) lost saw the deceased alive on <b>10-21-1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>John E. Kelly</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-2-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John E. Kelly</b>				22e. ADDRESS <b>9715 Medical Center Drive, Rockville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/5/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Monte Vista Park Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bluefield, West Virginia</b>	
24. FUNERAL DIRECTOR <b>Tyner Wheeler Funeral Home, Inc.</b> <b>1331 Rockville Pike Rockville, Maryland 20852</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 4 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

30868

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Edna L Whorton</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-7-1983</b>		2b. HOUR <b>11:25 AM</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 29, 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>76</b>	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Dickerson Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery.</b> MD	
10. CITY OR TOWN OF DEATH <b>Takoma Park.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Washington Adventist Hospital.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker.</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Maryland.</b>		13b. COUNTY <b>P. G.</b>		13c. CITY OR TOWN <b>Takoma Park.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME <b>Thomas J. Shreve.</b>		15. MOTHER'S MAIDEN NAME <b>Stella Heffner.</b>		16. STREET ADDRESS <b>6604 Westmoreland Ave.</b>		17. INFORMANT <b>Brother</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No.</b>		16b. SOCIAL SECURITY NO. <b>578-46-3808</b>		17. INFORMANT <b>D. Edward B. Shreve.</b>		17. INFORMANT <b>Brother</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4100</b> IMMEDIATE CAUSE (a) <b>acute myocardial infarct with</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>cardiogenic shock and low output.</b> 12 hrs (c) <b>chronic systolic hypertension</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>chronic anxiety</b>							
19a. DATE OF OPERATION <b>NA</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	
21a. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21b. LOCATION STREET CITY OR TOWN COUNTY STATE		21c. LOCATION STREET CITY OR TOWN COUNTY STATE		21d. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>3-20-1978</b> to <b>11-7-1983</b> , that (I) (last) saw the deceased alive on <b>11-7-83</b> , and that in (my) (last) opinion death occurred on the date and hour and from the causes stated above. (I) (last) (did not) view the body after death.							
22b. SIGNATURE <b>Fredrick G. Brennwald</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-8-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>F.W. BRENNWALD</b>		22e. ADDRESS <b>831 University Blvd E, Silver Spring</b>		22f. ADDRESS <b>831 University Blvd E, Silver Spring</b>		22g. ADDRESS <b>831 University Blvd E, Silver Spring</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial.</b>		23b. DATE <b>Nov. 11, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mononacy</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Beallsville, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Takoma Funeral Home, Inc.</b>		24. FUNERAL DIRECTOR ADDRESS <b>254 Carroll St. N. W. D. C.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 9 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carls</b>	

BP

WASHINGTON  
JAN 20 1907

Mr. J. B. ...  
Washington ...  
J. B. ...

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 8 6 9

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Helen M. Wheeler			2a. DATE OF DEATH MONTH DAY YEAR November 17, 1983		2b. HOUR 3:30 A.M.
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR July 23, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD	
10. CITY OR TOWN OF DEATH Kensington	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9613 Barroll Lane		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Kensington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 9613 Barroll Lane Zip: 20895
14. FATHER'S NAME FIRST MIDDLE LAST Arthur H. Tew		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amanda Smith			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-48-3637		17. INFORMANT ADDRESS Ann W. Ryan, Daughter, Same as item #13	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Adeno Carcinoma of Lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 1.5 years					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>June 1</u> , 19 <u>83</u> , to <u>Nov 16</u> , 19 <u>83</u> , that (I) (we) lost above, the deceased alive on <u>Nov 12</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Eric S. Groves</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Nov. 17, 1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eric Groves, M.D.		22e. ADDRESS Naval Medical Command National Capital Region, Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Nov. 21, 1983	23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey		P.A., Bethesda, Maryland		25a. DATE REC'D. BY REGISTRAR NOV 17 1983	
		25b. REGISTRAR'S SIGNATURE <u>John J. Smith</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

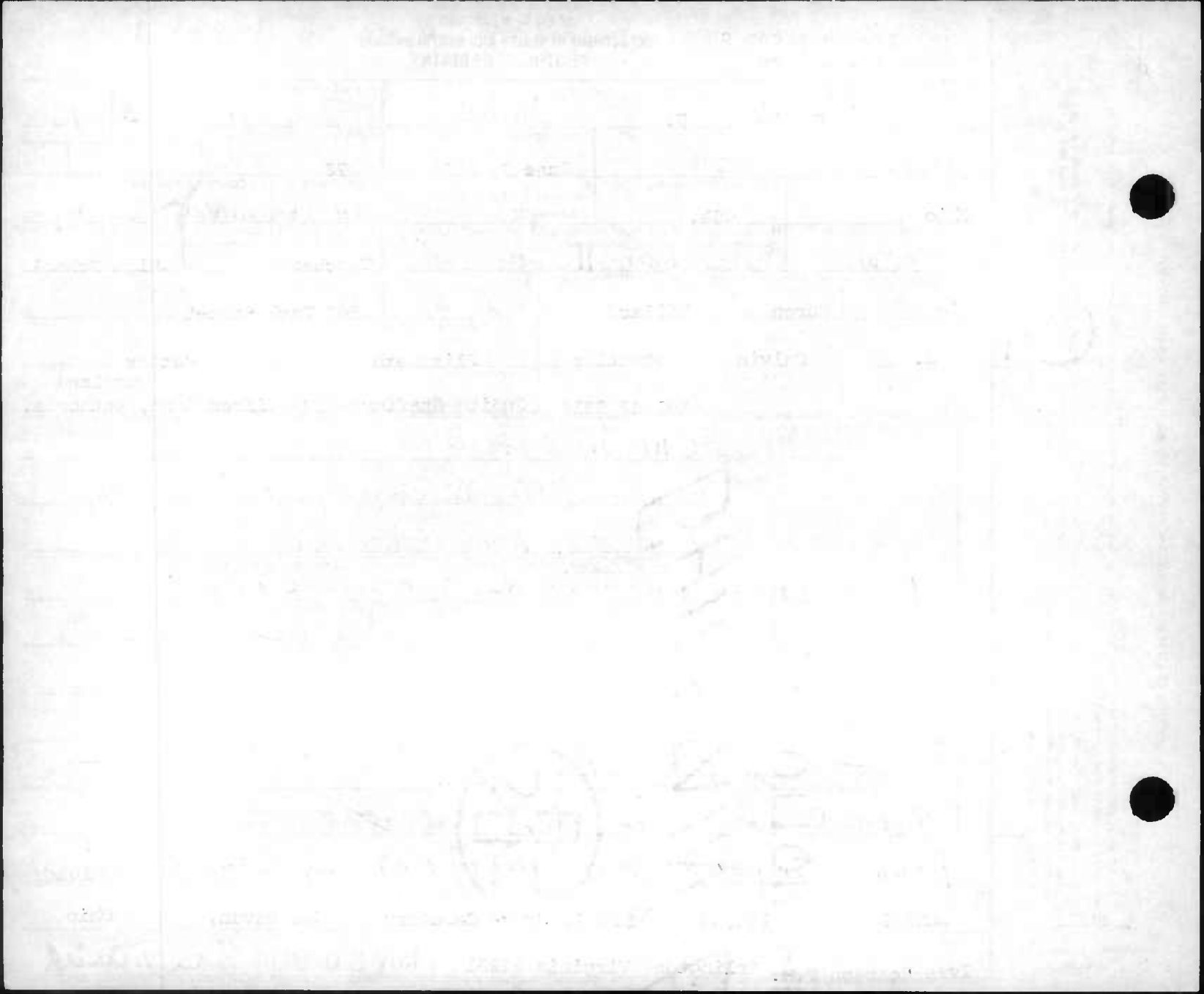


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 10-12 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR 12-8-83 cn				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		30870	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		2b. HOUR	
Naomi G. Wiebe				11.26.83		2:35 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		WHITE		June 9, 1905		78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Ohio		USA.				Montgomery County MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Suburban Hosp.		Teacher		High School	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Ohio		Huron		Willard		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
H. Calvin		Elizabeth		No		281 42 5314	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2506		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Judith Stafford		6909 Wilson Lane, Bethesda, Maryland		(b) Ischemic, diabetic congestive cardiomyopathy			
				(c) Diabetes, Atherosclerosis			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
Right hemiparesis due to cerebral emboli							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11-18, 1983, to 11-26, 1983, that (I) (we) lost the deceased alive on 11-26, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
Roland Imperial MD							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
ROLAND IMPERIAL MD		4977 BATTERY LANE Bethesda MD		Burial		Nov. 30, 1983	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
Maple Grove Cemetery		New Haven, Ohio		Ives-Pearson F.H. Arlington, Virginia 22201		NOV 30 1983	
						25b. REGISTRAR'S SIGNATURE	
						John J. Connel	







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IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

30871

 1- FOR  
 STATE  
 REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>DORIS</b> <b>Z.</b> <b>WIENER</b>			2a. DATE OF DEATH MONTH <b>NOVEMBER</b> DAY <b>2</b> YEAR <b>1983</b>		2b. HOUR <b>1:54 PM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>NOVEMBER 3, 1915</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		8. IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON, DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PATIENT AFFAIRS</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. NAVAL HOSPITAL</b>				
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>	
14. FATHER'S NAME FIRST <b>JERMIAN</b> MIDDLE <b>ZUKOFF</b> LAST <b>ZUKOFF</b>			15. MOTHER'S MAIDEN NAME FIRST <b>FREDA</b> MIDDLE <b>KOHN</b> LAST <b>KOHN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>111-22-9966</b>		17. INFORMANT <b>FREDRIC H. WIENER, 1731 UNIVERSITY BLVD., W. SILVER SPRING, MARYLAND</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>2502</b> IMMEDIATE CAUSE (a) <b>diabetes mellitus/sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>gastrointestinal hemorrhage; diabetic coma; gangrenous ulcer</b>						
19a. DATE OF OPERATION <b>10/5; 10/17; 10/26</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>GI bleeding; ulcer port x2</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>9/26</b> 19 <b>83</b> , to <b>11/2/83</b> 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>11/1/83</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Stanley M. Kirson</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/2/83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>STANLEY M. KIRSON, M. D.</b>		22e. ADDRESS <b>8830 CAMERON STREET SILVER SPRING, MARYLAND</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/3/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>KING DAVID MEMORIAL GARDEN</b>		
23d. LOCATION CITY OR TOWN <b>FALLS CHURCH, VIRGINIA</b>		23e. DATE RECORDED BY REGISTRAR <b>NOV 04 1983</b>				
24. FUNERAL HOME <b>DR. J. M. STEIN HEBREW MEMORIAL FUNERAL HOME</b>		25. REGISTRAR'S SIGNATURE <b>John J. [Signature]</b>				
24a. ADDRESS <b>232 CARROLL STREET, N. W., WASHINGTON, D. C.</b>						

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30872

1. FOR  
STATE  
REGISTRAR

REG. NO.

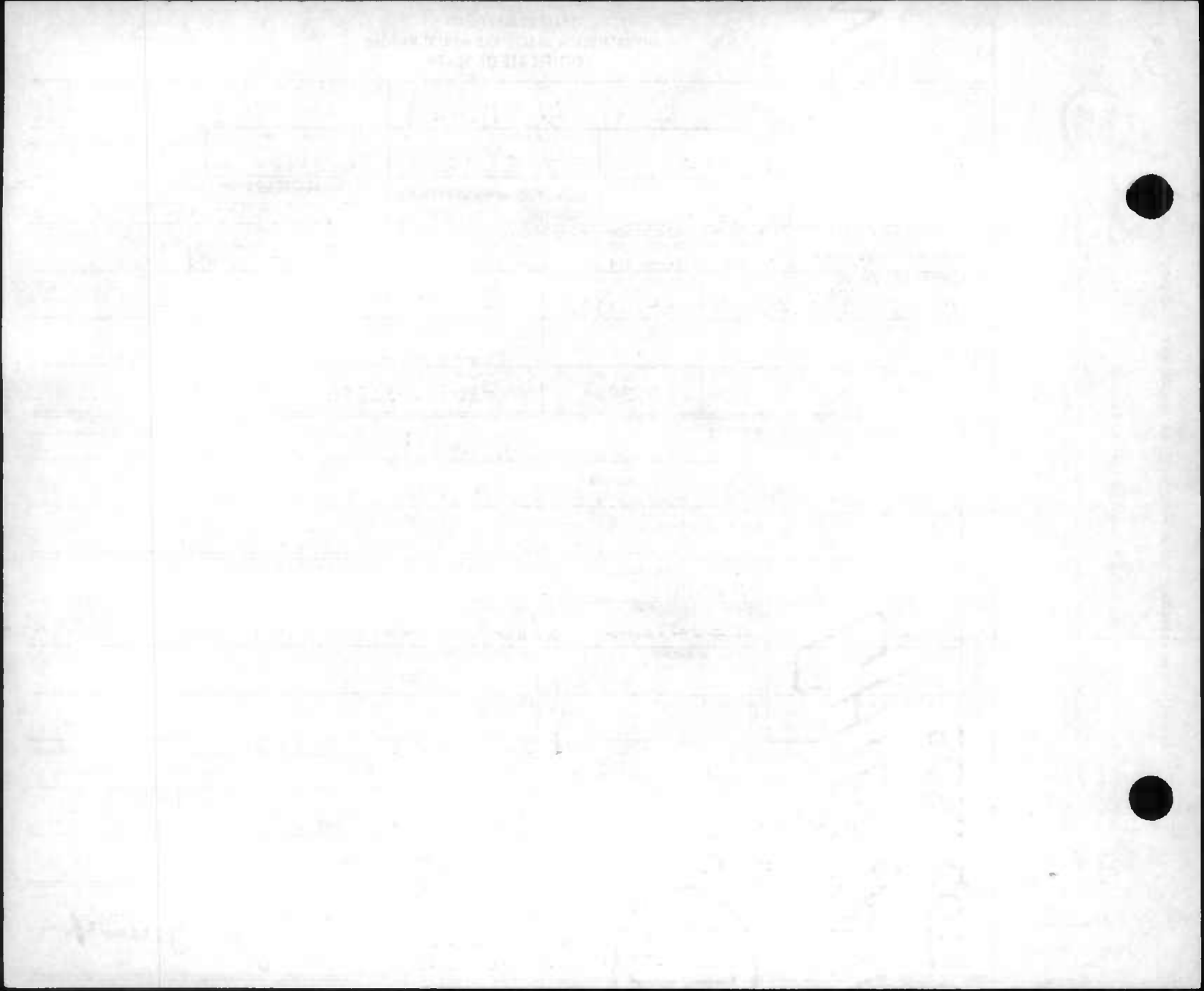
1. DECEASED NAME (TYPE OR PRINT) <b>Bertha Williams</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-17-83</b>		2b. HOUR <b>8:27 PM</b>
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 1 1938</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>45 yr</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ALABAMA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>TAKOMA PARK, MARYLAND MD.</b>	
10. CITY OR TOWN OF DEATH <b>MONTGOMERY</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Wash Adventist Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Computer Prog.</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MD</b>		13b. COUNTY <b>P.G.</b>	13c. CITY OR TOWN <b>Hyttsville</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>1410 Kanawha Street</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Zackery Smith</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Christine Bryant</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	
16b. SOCIAL SECURITY NO. <b>029-28-6567</b>		17. INFORMANT ADDRESS <b>Marlene Williams-2480 16th Sts., N.W.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: <b>1539 IMMEDIATE CAUSE (a) Carcinoma of Colon</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of Colon - Metastasis to Lung, Liver</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>Bronchopneumonia, Pneumothorax</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Hematuria, Anemia, Obesity</b>					
19a. DATE OF OPERATION <b>10/24/83</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma Colon</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>10/24/83</b> to <b>11/17/83</b> , that (I) (we) last saw the deceased alive on <b>11/17/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>[Signature]</b>		DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-18-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Vivex C VAID</b>		22e. ADDRESS <b>7676 New Hampshire Ave.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/25/83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Pottsville</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Lowell Mass</b>
24. FUNERAL DIRECTOR NAME <b>Morrow &amp; Woodford, Inc.</b>		ADDRESS <b>Wash., D. C. -1622 11th St. N.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 23 1983</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of fact.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For the purpose of this law, the death certificate is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>EDWARD I WILLIAMS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 29, 1983</b>			2b. HOUR M <b>11:05 A.</b>			
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>APR 28, 1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>91</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>SOUTH CAROLINA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY CO., MD.</b>			
10. CITY OR TOWN OF DEATH <b>CHEVY CHASE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BETHESDA RET. &amp; NURSING CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>EXECUTIVE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>STONE CO.</b>	
13a. STATE <b>VA.</b>		13b. COUNTY <b>FREDERICK</b>		13c. CITY OR TOWN <b>WINCHESTER</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>201 BEECHCRAFT RD., 99999</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>EDWARD C. WILLIAMS</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARIE ELOISE CHAZAL</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>			
16b. SOCIAL SECURITY NO. <b>NW I</b>			16c. SOCIAL SECURITY NO. <b>253-05-3563</b>			17. INFORMANT ADDRESS <b>FRANCES W. CARNEY, WOODVILLE, VA.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4292 IMMEDIATE CAUSE (a) CARDIAC ARREST</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 MINUTES</b>	
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b> (c)								10 YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>1. PARKINSON'S DISEASE 2. ASPIRATION PNEUMONITIS</b>									
19a. DATE OF OPERATION <b>NIA</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NIA</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NIA <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>NIA 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>NIA</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>NIA</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>NIA</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 30, 1981</b> to <b>NOV 11, 1983</b> , that (I) (we) lost the deceased alive on <b>NOV 4, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE <b>ARGH and MD</b>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/29/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DENNIS J. HAND MD</b>				22e. ADDRESS <b>4600 CONNECTICUT AVE NW WASHINGTON DC 20008</b>					
23a. BURIAL, CREMATION, REMOVAL BY <b>BURIAL</b>		23b. DATE <b>12-9-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PROSPECT HILL</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>FRUIT ROYAL, WARREN, VA.</b>			
24. FUNERAL DIRECTOR (NAME) <b>MADDOX FUNERAL HOME, INC.</b>				ADDRESS <b>FRONT ROYAL, VA.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 5 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carney</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) James C. Willyard			2a. DATE OF DEATH MONTH DAY YEAR Nov. 21, 1983		2b. HOUR 10:30PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 27, 1938	6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Dakota	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 14204 Notley Road,		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Analyst		12b. KIND OF BUSINESS OR INDUSTRY Pvt. Business
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Curtis G. Willyard		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Freda Joroy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Georgette O. Willyard-wife-(same as 13e)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Non Hodgkins Lymphoma</u> 2028 } DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 1/2 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Hemorrhage, Apathy, Pneumonia, Pancytopenia</u>					
19a. DATE OF OPERATION <u>8/29</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21b. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>May 8, 1972</u> , to <u>Nov 21, 1983</u> , that (I) (we) lost saw the deceased alive on <u>Nov 11, 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Israel Spector MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11/22/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Israel Spector, MD		22e. ADDRESS 12001 Ferrara Ave., Wheaton, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11/23/83	23c. NAME OF CEMETERY OR CREMATORY Norbeck Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Olney Mont. Maryland	
24. FUNERAL DIRECTOR Hines/Rinaldi 11800 New Hampshire Ave. S.S. Md		25a. DATE REC'D. BY REGISTRAR NOV 23 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Linnick</u>	

Hemorrhage, Cystitis, Prostatitis, Pyelitis

Non Hodgkins Lymphoma

8 1/2 years

Good patient no

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11/55/83

Nov 11 83 Nov 8 83 Nov 21 83



FOR  
1 - STATE  
REGISTRAR

SADYE WILSON

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Wilson, Sadye</b>			2a. DATE OF DEATH MONTH <b>11</b> / DAY <b>22</b> / YEAR <b>83</b>			2b. HOUR <b>12:58 P</b>					
3. SEX <b>F</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH <b>2</b> / DAY <b>26</b> / YEAR <b>91</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> / DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> / MIN. <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Tenn</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIAGE STATUS NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Beth. Health Care Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>99999</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MD</b> COUNTY <b>Dist of Col</b>		13b. CITY OR TOWN <b>WASH D.C.</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1436 K Street SE WASH DC 20003</b>					
14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b>SCOTT</b> LAST				15. MOTHER'S MAIDEN NAME FIRST <b>Bethesda</b> MIDDLE <b>20815</b> LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <b>UNKNOWN</b>				16b. SOCIAL SECURITY NO. <b>577-84-3093</b>		17. INFORMANT ADDRESS <b>Bethesda Health Care Center 8721 Gasvevor lane Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: <b>4254</b> IMMEDIATE CAUSE (a) <b>Coronary Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Coronary atherosclerosis</b> (c) <b>Diabetic gangrene</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>10/11/83</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART 1 OR PART 2) <b>date</b>							
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN <b>Knoxville</b> COUNTY <b>Tenn</b> STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>11/19/83</b> to <b>11/22/83</b> , that (I) (we) last saw the deceased alive on <b>11/19/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Thos G. Ward MD</b>				22c. DATE SIGNED <b>11/22/83</b>				22d. ADDRESS <b>WARD, GILLERBINWOOD, Bethesda, MD 20817</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-28-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Crestview</b>				23d. LOCATION CITY OR TOWN <b>Knoxville</b> COUNTY <b>Tenn</b> STATE			
24. FUNERAL DIRECTOR NAME <b>John T. Rhines Co., 3015 12th St. N.E., D.C.</b> ADDRESS <b>20003</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 25 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John T. Rhines</b>			

1. Name of the plant or animal  
2. Name of the collector  
3. Date of collection  
4. Locality  
5. Description of the specimen  
6. Remarks  
7. Name of the person to whom the specimen is loaned  
8. Date of loan  
9. Name of the person to whom the specimen is returned  
10. Date of return

BH

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JULIAN PHINEAS WOLF			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 4, 1983		2b. HOUR P M 6:25
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR MAY 13, 1902	6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.		
10. CITY OR TOWN OF DEATH BETHESDA,	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE CLINICAL CENTER, NIH		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner (Retired)	12b. KIND OF BUSINESS OR INDUSTRY Women's Clothing	
13a. STATE Massachusetts			13b. COUNTY unknown	13c. CITY OR TOWN Longmeadow	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Aaron		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fanny Drachman		13e. STREET ADDRESS 47 Englewood road 01106	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I	17. INFORMANT Mrs. Wilhelmina Wolf (wife)		ADDRESS SAME AS ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4254 IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>status-post cardiac surgery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Hypertrophic Cardiomyopathy/Aortic stenosis</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION 10/27/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Aortic stenosis		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>October 16,</u> 19 <u>83</u> , to <u>November 4,</u> 19 <u>83</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>November 4,</u> 19 <u>83</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.			
22b. SIGNATURE Eugenia Legan MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 11/5/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENIA LEGAN		22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MARYLAND 20205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 11-5-1983	23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike		25a. DATE REC'D. BY REGISTRAR 8 1983		25b. REGISTRAR'S SIGNATURE James G. Conish	

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

(M)

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MEMORANDUM

11-2-1983

Rockwell

Rockwell International Corporation  
11111 Rockwell Drive  
Rockwell, California 92650

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, but before it is filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Perry Austin Wood			2a. DATE OF DEATH MONTH DAY YEAR 11-24-83		2b. HOUR 4:30 AM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 6 18 98		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Welder		12b. KIND OF BUSINESS OR INDUSTRY Electric
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Gaithersburg	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Byron Wood		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 175-09-0312		17. INFORMANT Son Richard Bruce Wood	
				ADDRESS Same as 13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septaecaemia (Possible-)</u> 4148 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> Urinary Tract Infection Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
--	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Hypothyroid, Chronic Obstructive Lung disease.</u>			
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19a. DATE OF OPERATION N/A	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> N/A	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A	21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A	
22a. I certify that (I) (this hospital) attended the deceased from <u>11-9-83</u> , 19 <u>83</u> , to <u>11-24-1983</u> , that (I) (we) last saw the deceased alive on <u>11-23-1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Raman R. Mehra		22c. DATE SIGNED 11-24-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAMAN R. MEHRA MD		22e. ADDRESS 16220 Frederic Road #503 Gaithersburg MD. 20877	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Nov. 27, 1983	23c. NAME OF CEMETERY OR CREMATORY North East Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE North East Erie Pennsylvania
24. FUNERAL DIRECTOR NAME Francis J. Collins ADDRESS 500 University Blvd., West Silver Spring, Md.		25a. DATE REC'D BY REGISTRAR DEC 2 1983	25b. REGISTRAR'S SIGNATURE John J. Connel

1910-11-10



*[Faint, mostly illegible handwritten text, possibly a letter or report, covering the main body of the page.]*

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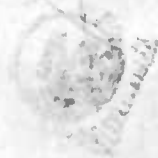
3 0 8 7 8

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Minnie</b>		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
						<b>S. Wooten</b>		<b>11</b>		<b>12</b>		<b>83</b>		<b>10:30</b>		<b>P</b>	
3. SEX <b>F</b> Female		4. RACE <b>White</b>		5. DATE OF BIRTH		MONTH		DAY		YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		8. YRS.		IF UNDER 1 YEAR	
				<b>May</b>		<b>7</b>		<b>1899</b>				<b>84</b>				IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>											
10. CITY OR TOWN OF DEATH <b>Olney Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>											
13a. STATE <b>N. Carolina</b>		13b. COUNTY <b>Guilford</b>		13c. CITY OR TOWN <b>Greensboro</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET ADDRESS <b>2704 Brme Road</b>									
14. FATHER'S NAME FIRST <b>Charles</b> MIDDLE <b>T.</b> LAST <b>Edwards</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Dora</b> MIDDLE <b>Unknown</b>															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>N/A</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>N/A</b>		17. INFORMANT <b>Mrs. Dotie Bruening-dau-Sil.</b>		ADDRESS <b>201 Hornell Drive, Sil. Spr. Md. 20904</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4360</b> IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b>		DUE TO, OR AS A CONSEQUENCE OF (b) <b>Major cerebrovascular accident</b>		DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>11/12/83</b>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>Pharyngeal cancer, Pneumonia, CVA's</b>																	
19a. DATE OF OPERATION <b>11/12/83</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b></b>													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b></b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b></b>													
22a. I certify that (I) (this hospital) attended the deceased from <b>4/1/83</b> to <b>11/12/83</b> , that (I) (we) last saw the deceased alive on <b>11/12/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.																	
22b. SIGNATURE <b>[Signature]</b>		DEGREE <b></b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/13/83</b>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>[Signature]</b>		22e. ADDRESS <b>18111 Prince Philip Dr, Olney, MD 20832</b>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-15-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lakeview Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Greensboro Guilford N. Car.</b>											
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi Funeral Home</b>		ADDRESS <b>11800 N.H. Ave., Silver Spring, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1983</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>											





87 10:50

Wooten

M. O. L.

Montgomery

Montgomery General Hospital

Oliney M. D.

80% COTTON



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. THIS CERTIFICATE IS TO BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR		
Charles Robert Wyatt						11 4 19 83						M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR		
Male	Caucas.	Apr. 26, 1952	31 YRS.			11 4 19 83						11:29 p.m.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH					
Washington DC			United States			NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Montgomery County, MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Silver Spring			Holy Cross Hospital			Video Technician			Cable T.V.					
13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET ADDRESS														
Maryland Montgomery Rockville YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 14217 Greenspan Lane 20853														
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME								
Charles E. Wyatt						Eleanor Godsey								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
Yes						1972-1974			220 60 0521			Mother Eleanor Wyatt Same as item 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														
PART I DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) <u>Stab wound of chest</u>														
DUE TO, OR AS A CONSEQUENCE OF														
(b) _____														
DUE TO, OR AS A CONSEQUENCE OF														
(c) _____														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY?														
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY?														
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR XX MONTH DAY YEAR 1035 P.M. 11 4 1983 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject stabbed														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) house 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 12906 Flack St. Silver Spring Mont. Md.														
22a. I certify that I took charge of the deceased described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>														
TITLE (SPECIFY) Deputy Chief MEDICAL EXAMINER														
ACTUAL SIGNATURE DATE SIGNED 11/5/83														
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. ADDRESS 111 Penn St. Balto., MD.														
23a. BURIAL, CREMATION, REMOVAL 23b. DATE Nov. 9, 1983 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION CITY OR TOWN COUNTY STATE														
Cremation 9, 1983 Metropolitan Crematory Alexandria Virginia														
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE														
NOV 14 1983														

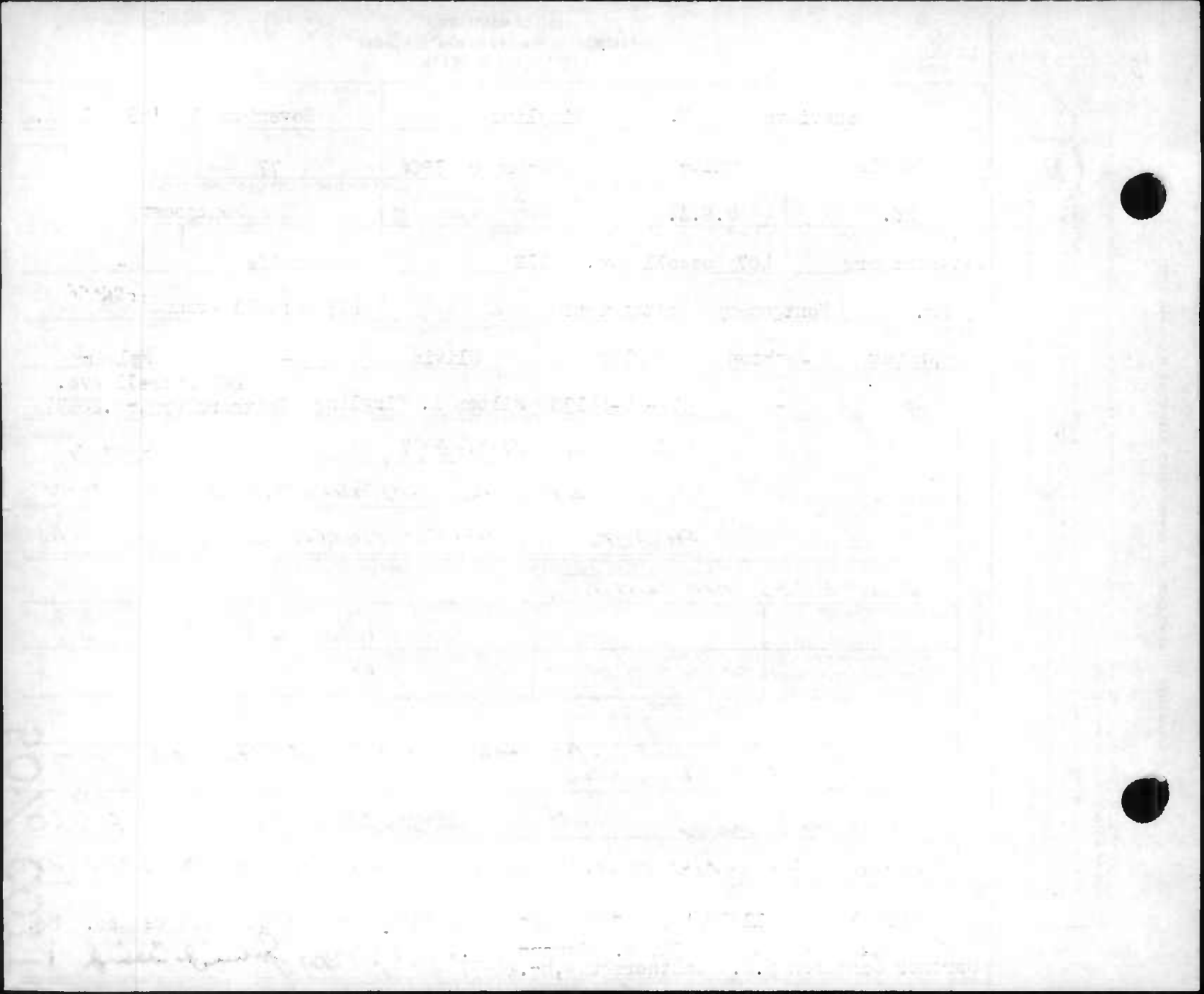


STATE OF MARYLAND 3 3 0 8 8 0  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Genevieve T. Yingling</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 8 1983</b>		2b. HOUR <b>1 A.M.</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>November 6 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS. <b>77 YRS.</b> MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>	
10. CITY OR TOWN OF DEATH <b>Gaithersburg</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>407 Russell Ave. #112</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>Md.</b>	13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Gaithersburg</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>407 Russell Avenue 20877</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Andrew Jackson Taylor</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Olivia - Melvin</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>579-01-6413B</b>		17. INFORMANT ADDRESS <b>Milton L. Yingling 407 Russell Ave. Gaithersburg, Md. 20877</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MYO CARDIAC INFARCTION</b> 31 NOV DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTERIO SCLEROTIC HEART DISEASE</b> 25 YRS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>DIABETES MELLITUS</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 46</b> , 19 <b>1964</b> , to <b>OCT 15</b> , 19 <b>83</b> , that (I) <del>was</del> last saw the deceased alive on <b>OCT 15</b> , 19 <b>83</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I <del>was</del> did not) view the body after death.					
22b. SIGNATURE <b>John F. O'Connor MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/8/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John F. O'Connor MD</b>		22e. ADDRESS <b>5218 CUSCOSEN AVE BETHESDA, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/10/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood Prince Geo. Md.</b>					
24. FUNERAL DIRECTOR <b>Robert B. Sandison 316 E. Diamond Ave., Gaithersburg, Md. 20877</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 10 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connelley</b>	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <i>William Zelinka</i>						2a. DATE KNOWN OF DEATH ESTIMATED <i>Nov 17 1983</i>		2b. HOUR <i>7:56</i>		2c. DATE <i>Nov 17 1983</i>	
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Feb 03 80</i>	6. AGE IN YEARS YEARS MONTHS DAYS <i>3 YRS.</i>	7. IF UNDER 1 YR. MONTHS DAYS <i>0</i>	8. IF UNDER 24 HRS. HOURS MIN. <i>0</i>	7c. DATE PRONOUNCED DEAD <i>Nov 17 1983</i>		7d. HOUR <i>7:56</i>		7e. DATE <i>Nov 17 1983</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Illinois</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i>					
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>1001 Spring St. Apt 414</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Teamster</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>20910</i>			
13a. STATE <i>MD</i>		13b. COUNTY <i>Mont.</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>1001 Spring St. Apt. 414</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>John Zelinka</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ann Krull</i>				16. ADDRESS <i>912 25th St., N.W. Washington, D.C. 20037</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>318-09-0433</i>		17. INFORMANT <i>Son</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: <i>4291 Acute Myocardial Infarction</i> IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____											
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>None</i>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John S. Rogers</i>		TITLE (SPECIFY) <i>Dep.</i>		MEDICAL EXAMINER				DATE SIGNED <i>Nov 18 1983</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>John S. Rogers, M.D.</i>		ADDRESS <i>1919 Seminary Road Silver Spring, Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Nov. 19, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Silver Spring Mont. Md.</i>			
24. FUNERAL DIRECTOR NAME <i>Francis J. Collins</i>		ADDRESS <i>500 University Blvd., W. Silver Spring, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>NOV 25 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Lohr</i>					

*[Faint, illegible handwriting throughout the page]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Men. ...

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>George A. Zimmerman</b>					2. DATE OF DEATH MONTH DAY YEAR <b>11-21-83</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 9, 1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.		7. HOUR <b>4 55 AM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUBURBAN Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired- Equitable Life Ins.</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1702 Viers Mill Road 20851</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Oscar Zimmerman</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna G. Reinher</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>115-03-1710</b>		17. INFORMANT ADDRESS <b>Laura O. Zimmerman same as 13e</b>					
18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: <b>2050 ACUTE MYELOIDIC LEUKEMIA</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 MONTHS</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>BRONCHOPNEUMONIA</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>8-6-</b> , 19 <b>71</b> , to <b>11-21-</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>Nov. 20</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Stephen W. DeJeter</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11-21-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>STEPHEN W. DEJETER M.D.</b>				22e. ADDRESS <b>6719 WILSON LANE, BETHESDA, MD 20817</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/23/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rockville, Maryland</b>			
24. FUNERAL DIRECTOR <b>Wheeler Funeral Home, Inc.</b> <b>1331 Rockville Pike Rockville, Maryland 20852</b>						25a. DATE REC'D BY REGISTRAR <b>NOV 25 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. [Signature]</b>	

BP

This image shows a blank, aged, cream-colored page, likely an endpaper or flyleaf from an old book. The paper has a slightly textured appearance with some minor creases and discoloration, characteristic of old paper. Two dark circular holes are visible near the right edge, possibly from a binder or punch. Faint, illegible text is visible through the paper, suggesting bleed-through from the reverse side. The left edge of the page shows the binding structure, including a vertical strip of material and some stitching or staples. The overall tone is warm and historical.



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER MUST SIGN AND DATE THE BOTTOM OF PAGE 1, 2, AND 3 TO THE FUNERAL PERMIT. PAGES 1, 2, AND 3 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR RECORDS.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN TWO HOURS OF DEATH, IN THE BUREAU'S FILES. PAGES 1 AND 2 SHOULD BE SUBMITTED TO THE DIVISION OF VITAL RECORDS, 301 W. BALTIMORE STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION OR REMOVAL.

## MEDICAL CERTIFICATION

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				30883					
1. DECEASED NAME (TYPE OR PRINT)						2a. DATE KNOWN OF ESTL. MATED				2b. HOUR	
Louis J. Zwicharowski						MONTH DAY YEAR 11 14 83				1:45 A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.	
Male		White		MONTH DAY YEAR 12 4 1925		LAST BIRTHDAY 57 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)						7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Penna.						U.S.A.				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH						11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Rockville						12612 Viers Mill Road Apt. # 104				Retired - Window Washer	
13a. STATE						13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland						Montgomery		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Joseph Zwicharowski						Anna Austin					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)						16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No						209 18 3725		Esther I. Zwicharowski Same as item 13a-c			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4960 Respiratory arrest. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. chronic obstructive (b) pulmonary disease. (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John F. Tauber				TITLE (SPECIFY) M.D.				DATE SIGNED 11-15-83			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
John F. Tauber				8218 Wisc. Ave. Bethesda, Md. 20014							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		11-16-83		Parklawn Memorial Park				Rockville Montgomery Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852						NOV 18 1983		J. E. C. C. C.			

